

OASIS-C Best Practice Manual Developed at the National OASIS-C Best Practice Forum

Sponsored by: **Delta Health Technologies**

Co-sponsored by: National Association for Home Care & Hospice Fazzi Associates, Inc.

January 2010





Dear Homecare Professional:

Delta Health Technologies is honored to be the sponsor of the Delta National OASIS-C Best Practice Project and we are extremely pleased to present you with the National OASIS-C Best Practice Manual. Delta Health Technologies has sponsored this national effort to provide homecare practitioners with the best guidance possible for the completion of the OASIS-C data set.

Words cannot describe the commitment, energy, and passion (and yes, we do mean passion!) that has gone into the contents of this report. More than 70 clinical experts from around the nation spent nearly 50 hours working through each OASIS-C question. They first sought to understand the intent of the question and then to provide guidance on how best to respond and ensure accuracy in the responses. Countless additional hours have been invested making edits and revisions to create the best possible final product.

We value your contribution in our communities by making it possible for neighbors and loved ones to receive care in their own homes. We appreciate the business relationships and trust that we have built with you during our involvement in homecare and hospice, dating back to 1974. It is in this spirit of caring and thankfulness that we have decided to give back to the industry that is so vital to our families and our livelihood. We have underwritten this important work so that it could be provided to all who ask from within our industry, whether a provider, a consultant, or a vendor.

Delta customers will have the entire contents of this report - including live links to expert reference material - available at the patient's bedside, just a click away. Delta Health Technologies offers your agency unparalleled expertise, customizable solutions and a fanatic commitment to your success.

Thank you once again for your contributions to our industry.

Sincerely,

Keith R. Crownover President & CEO

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National Association for Home Care & Hospice

The National Association for Home Care & Hospice (NAHC) was pleased to co-sponsor the Delta National OASIS-C Best Practices Project. NAHC has been continually committed to supporting the important work of home care's tens of thousands of caring and compassionate care givers. We recognize that the new OASIS-C assessment form is an important advancement in our country's efforts to provide clinicians with tools to better assess the physical and health needs of millions of home care patients throughout the country.

We also recognize that the new form includes new questions and new challenges for our clinicians. What made the OASIS-C Project so powerful and exciting is the fact that we recruited nearly 100 of home care's leading and most respected clinicians from throughout the country, all either appointed or nominated by their state associations, to work on this project. Their efforts coupled with the input from hundreds more lead to the development of best practice strategies, tips and techniques designed to help clinicians obtain more accurate assessments of patient needs. We are proud and excited to present to you this document and extend our best wishes and sincere admiration for the incredible work you do.

Mary J. L. Gine

Vice President of Regulatory Affairs
National Association for Home Care & Hospice



Fazzi Associates

Fazzi Associates was pleased and proud to have been asked to design, develop and facilitate the Delta National OASIS-C Best Practices Project and the OASIS-C Best Practice Forum, the actual venue where the national experts created the foundation for this document. Since the inception of OASIS, Fazzi Associates has provided OASIS trainings and audits to agencies throughout the country, we have researched OASIS extensively and we were one of original sponsors of the OASIS Integrity Manual. What we knew from our work and our clients was that OASIS-C was not just an important instrument; it was an instrument that was both complex and challenging. It had significant implications to the quality and financial viability of every Medicare certified agency in the country. It was critical that agencies get the very best information possible on best practices strategies for completing the form in a timely and quality manner.

Thanks to the gracious sponsorship of Delta Health Technologies, the co-sponsorship of NAHC and the incredible talent, dedication, and knowledge of the OASIS Experts throughout the country who participated on the project, we have collectively created a manual that contains exceptional recommendations on best practice strategies, practices and tips for generating more accurate OASIS assessments. There is no question that the contents of this manual will serve as the foundation for OASIS trainings and for informed decision making by clinicians throughout the country. Our thanks to all those who made the vision of the project a reality!

Dr. Robert Fazzi, Managing Partner

Fazzi Associates, Inc.



A Special Note of Thanks

The Delta National OASIS-C Best Practice Project would like to express our sincere thanks and appreciation to the National Steering Committee and to the OASIS-C Clinical Experts who committed a great deal of their time, energy, knowledge and expertise to make this manual and these recommendations possible. Your individual and collective contributions will directly impact the accuracy and quality of OASIS assessments being provided to millions of patients throughout the country. This project and our industry as a whole are clearly indebted to you and to your agency for supporting your involvement.

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National OASIS-C Best Practice Manual

The National OASIS-C Best Practice Manual represents the work of hundreds of home care leaders throughout the United States.

Sponsored by Delta Health Technologies and co-sponsored by the National Association of Home Care & Hospice, and Fazzi Associates, the OASIS-C Best Practice Project entailed a systematic effort on the part of the home care industry to come up with best practices, techniques, and strategies for all the OASIS-C items. The effort involved a six-month, five phase process:

- Phase I. Creation of National Steering Committee: A national steering committee was formed made up of representatives of every region in the country. The committee also represented large and small agencies, urban, rural, hospital-based, affiliated, freestanding, profit, non-profit, and governmental.
- Phase II. Recruitment of National Experts: With the help of the National Association for Home Care & Hospice and state associations throughout the country, nearly 100 of home care's leading and most respected clinicians, all either appointed or nominated by their state associations, were recruited to participate in an intensive best practice development process, the National OASIS-C Best Practice Forum in Chicago, IL.
- **Phase III. National Input:** A national web site was created for clinicians and other home care leaders to provide suggestions and ideas for the national experts to consider at the National OASIS-C Best Practice Forum. This input proved to be an integral part of the process.
- **Phase IV. National OASIS-C Best Practice Forum:** During a two-day, intensive forum in Chicago, IL, the national experts reviewed every OASIS-C item and collectively generated best practice, strategies, tips, and techniques for helping to guide the efforts of clinicians doing OASIS-C assessments.
- Phase V. Review, Refinement and Finalization: The recommendations generated by the National Forum were then reviewed by clinical leaders from both NAHC and Fazzi Associates. Their review was then followed by a second review by Dr. Elizabeth Madigan, a CMS contractor and member of the faculty of Case Western University. A third review was then conducted by Fazzi Associates.

This document represents the final draft of all these efforts. Every OASIS-C item is included within this report. Every item has at least one suggestion with some having multiple suggestions. Ultimately, this document represents the collective creativity, knowledge and expertise of clinical leaders throughout the country who made the vision of this document a reality.

M0010	CMS Certification Number:	M0010
Item Inte	ent	
	s the agency's Centers for Medicare and Medicaid Services (CMS) certification number edicare provider number).	
Time Po	pints Item(s)	
SOC		

Optimal Question

• What is the agency's CMS assigned Medicare provider number for billing Medicare?

Optimal Strategy/Technique

- Obtain Medicare provider number from agency administrator or billing department.
- Pre-fill or pre-print this item on agency documents.

Tips

1. This is not the Provider's National Provider Identifier (NPI) number.

Time Points Item(s)

SOC

Optimal Question

• In which state is the branch location that will provide services to the patient?

Optimal Strategy/Technique

- Confirm with agency administrator which branch/state location will service the patient.
- Pre-fill or pre-print this item on agency documents.

- 1. Leave item blank if agency has zero branches or all branches are located in the same state.
- 2. Consult branch administrator and/or agency policy regarding (branch) strategies for out of state branches.

10016	Branch ID:	M0016

Item Intent

Specifies the branch identification code, as assigned by CMS. The identifier consists of 10 digits – the State code as the first two digits, followed by Q (upper case), followed by the last four digits of the current Medicare provider number, ending with the three-digit CMS-assigned branch number.

Time Points Item(s)

SOC

Optimal Question

What is the ID number assigned by CMS for the branch that will service the patient?

Optimal Strategy/Technique

- Confirm with agency administrator which branch/state location will service the patient and enter number assigned by CMS.
- Pre-fill or pre-print this item on agency documents.
- Update patient tracking item when changes occur during the episode.

- 1. Enter N followed by 9 blank spaces if agency has no branches.
- 2. Enter P followed by 9 blank spaces if service location is the "parent" that has branches.
- 3. Consult branch administrator and/or agency policy regarding (branch) strategies for out of state branches.

M001	8 National Provider Identifier (NPI) for the attending physician who has signed the plan of care:
	☐ UK – Unknown or Not Available
ltem	Intent
Iden	tifies the physician who will sign the Plan of Care
Time	Points Item(s)
SOC	
Optim	al Question
•	Which physician will sign the Plan of Care?
Optim	al Strategy/Technique
•	Look up NPI number in NPI registry: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do
•	Vendor software may auto-populate this item with current NPI Registry information.
Tips	
1.	NPI number assignments change. Keep list current.
2.	Update patient tracking item when changes occur during the episode.

Item Intent

Specifies the agency-specific patient identifier. This is the identification code the agency assigns to the patient and uses for record keeping purposes for this episode of care. The patient ID number may stay the same from one admission to the next or may change with each subsequent admission, depending on agency policy. However, it should remain constant throughout a single episode of care (e.g., from admission to discharge).

Time Points Item(s)

SOC

Optimal Question

None

Optimal Strategy/Technique

- Consult agency administrative staff for agency specific patient identifier.
- Vendor software to auto-populate document.

- 1. Use the same number from admission to discharge.
- 2. Protect patient privacy; this number should not be the patient's Medicare or social security number.

M0030	Start of Care Date:				
		montn	day	year	

M0030

Item Intent

Specifies the start of care date, which is the date that the first reimbursable service is delivered.

Time Points Item(s)

SOC

Optimal Question

Who made the first skilled and billable visit and on what date?

Optimal Strategy/Technique

Verify with agency administrative staff.

Tips

- The Start of Care date is the date of the first *reimbursable/billable* visit *to Medicare*. With a billable visit, *a* service (SN, PT, OT, SLP, HHA, MSW) is delivered per physician order **after** the patient has been accepted for care and it is determined that Medicare coverage criteria are met (42 CFR 409.46 Initial assessment visit). It is usually but may not always be the date the assessment is completed. It is usually but may not always be a nursing or therapy visit.
- When it is the agency practice and/or policy for nursing services to conduct the comprehensive assessment for a physician ordered rehab only case (this assumes the physician has not approved an order for skilled nursing services and the nursing visit is therefore not billable), the nurse must conduct the comprehensive assessment within the first 5 days of the episode. The nurse's visit must occur either the same date as the therapist's first skilled visit or afterward to be eligible and accepted for the episode. (42 CFR 484.55(a)(2)).
 - a. However, if the agency chooses, a nurse can conduct the "initial assessment visit" which is different from a comprehensive assessment (42 CFR 484.55(a)) to determine the immediate care and support needs of the patient and determine eligibility for the Medicare home health benefit, including homebound status prior to the first billable therapy visit. This determination alone would not be considered skilled or billable and does not establish the SOC date. Any additional clinical information gathered at the time of this "initial assessment visit" is not eligible to be included in the comprehensive assessment that includes OASIS data. Typically agencies will combine the initial assessment visit with the comprehensive assessment for efficiency. The data for the comprehensive assessment must be collected on the same day as the first billable visit (SOC) or within five days following the SOC. http://www.access.gpo.gov/nara/cfr/waisidx_99/42cfr484_99.html
- The SOC Comprehensive assessment must be completed within 5 calendar days after the SOC date (SOC= Day 0). Refer to OASIS Reference Sheet Version July 19, 2006, https://www.qtso.com/download/hha/OASIS_Ref_Sheet.07.19.06.pdf

Note: When the first reimbursable (SOC) visit is not performed by the professional conducting the comprehensive assessment, agencies may limit their ability to complete some care processes reported on in subsequent OASIS items where using the entire 5 day (SOC) window may be helpful for some patients (e.g., M2010 High Risk Drug Education, M2250 POC Synopsis, etc). Be as efficient as possible with collaboration, communication and workflow.

- When nursing is ordered as part of a multidiscipline referral and will provide a skilled and billable service, nursing <u>must</u> conduct the first visit which is the initial evaluation (assessment) visit and the comprehensive assessment combined. This establishes the start of care date. (42CFR 484.55(a))
- A skilled PT or SLP may perform the SOC visit for a Medicare patient when there are no orders
 present for nursing at the start of care.
- M0030 Start of Care is often but not always the same as M0090 Assessment completed date.
 Conducting best practices during the assessment process may affect this date.
- In special circumstances, consult OASIS Management for Single Visit at Start of Care or Resumption of Care http://www.qtso.com/hhadownload.html and OASIS Considerations for Medicare PPS Patients (Revised July 2009) www.cms.hhs.gov/oasis/downloads/OASISConsiderationsForPPS.pdf

M0032	Resumption of Care Date:///	☐ NA – Not Applicable	M0032
Item Int	ent		
Specifie	s the date of the first visit following an inpatient stay by a pati	ient receiving service from the	home

Time Points Item(s)

ROC

Optimal Question

health agency.

• What is the date of the first billable/reimbursable visit following an inpatient stay?

Optimal Strategy/Technique

- Consult agency administrative staff for most recent ROC date during the period of care.
- Update patient tracking sheet as needed.

- 1. A resumption of care occurs after a qualifying stay in an inpatient facility of > 24 hrs and not for observation or diagnostic testing.
- 2. ROC visit should be made and assessment completed within 2 calendar days of facility discharge or knowledge of patient's return home.
 - Note: This short time frame limits the ability of agencies to complete some of the processes reported on in subsequent OASIS items. Be as efficient as possible with collaboration, communication and workflow.
 - M0032 ROC is usually but not always the same as M0090 Date Assessment Completed.
 Conducting best practices during the assessment process may affect this date.
- 3. At SOC, select N/A.
- 4. At ROC, complete with actual date visit made.
- 5. In subsequent episodes, complete with the most recent ROC date.
- 6. Consult agency discharge policy regarding discharge or hold for resumption of care at the time of rehospitalization to determine if resumption of care is the correct action.
- Refer to OASIS Reference Sheet Version July 19, 2006, https://www.qtso.com/download/hha/OASIS_Ref_Sheet.07.19.06.pdf
- In special circumstances, consult OASIS Management for Single Visit at Start of Care or Resumption of Care http://www.qtso.com/hhadownload.html and OASIS Considerations for Medicare PPS Patients (Revised July 2009) http://www.cms.hhs.gov/oasis/downloads/OASISConsiderationsForPPS.pdf

M0040	Patient Name:			
(First)				Suffix) M0040
Item Inte	ent			
Specifies	the full name of the patient: t	first name, middle initial, last	name, and suffix (e.g., J	Ir., III, etc.).
Time Po	ints Item(s)			
SOC				

Optimal Question

• What name is on your Medicare/Medicaid card?

Optimal Strategy/Technique

- Look at the Medicare/Medicaid card in the field.
- Office based staff to obtain name in the Medicare/Medicaid on line systems when the referral is received.

- 1. If no Medicare/Medicaid card available, look at photo ID or a Medicare Explanation of Benefit notice.
- 2. If the name the patient uses conflicts with name in Medicare system, alert patient and consult agency administrative staff for guidance.

M0050 Patient State of Residence: ___



Item Intent

Specifies the State in which the patient is currently residing while receiving home care.

Time Points Item(s)

SOC

Optimal Question

• In what state am I providing services to this patient?

Optimal Strategy/Technique

Contact government officials if unsure of location.

- 1. Complete this item with the name of the state where you are visiting the patient and providing services, even if it is not where the patient usually lives.
- 2. Update patient tracking sheet when changes occur during the episode.

M0060	Patient Zip Code:	M0060
14 1		

Item Intent

Specifies the zip code for the address at which the patient is currently residing while receiving home care.

Time Points Item(s)

SOC

Optimal Question

• What is the zip code for this residence?

Optimal Strategy/Technique

• Look up zip code of location where services are being provided in a postal service resource guide.

- 1. Use zip code of residence where visiting the patient.
- 2. Update patient tracking sheet when changes occur during the episode.

M0063	Medicare Number:	(including suffix, if any)	☐ NA – Not Applicable	M0063
Item Int	ent			

For Medicare patients only. Specifies the patient's Medicare number, including any prefixes or suffixes. Use RRB number for railroad retirement program.

Time Points Item(s)

SOC

Optimal Question

• What is your Medicare number?

Optimal Strategy/Technique

Obtain number by looking at the red, white and blue Medicare card.

- 1. The Medicare card contains the "claim number" or Medicare number and the effective dates of hospital benefits (Part A) and medical benefits (Part B).
- 2. Look for the number on a recent Medicare Explanation of Benefits as an alternative.
- 3. The Medicare number is NOT the same as the Medicare HMO, Medicare Advantage or Medicare Part C number.
- 4. Enter the Medicare number any time it is known even if Medicare is not the payer for this episode of care.
- 5. Select NA:
 - if the patient does not have Medicare or
 - the Medicare number is unknown
- 6. Update patient tracking sheet as changes occur.

M006	4 Social Security Number: M0064
	☐ UK – Unknown or Not Available
ltem	Intent
Spec	sifies the patient's Social Security number.
Time	Points Item(s)
SOC	
Optima	al Question
•	What is your Social Security number?
Optima	al Strategy/Technique
•	Obtain number from social security card.
Tips	
1.	Accept "unknown" when patient is resistant to providing their social security number.
2.	Assure patient that all information is private and protected as disclosed to them through the SOC process.

M0065	Medicaid Number:	☐ NA – No Medicaid	M0065	
Item Inte	ent			
Specifies the patient's Medicaid number.				
Time Po	ints Item(s)			
SOC				
		·		

Optimal Question

• What is your Medicaid number? Have you received a new card recently?

Optimal Strategy/Technique

- Look at card in the patient's home and verify expiration date.
- Verify current eligibility through the state on line system.

- 1. Enter the Medicaid number when known even if Medicaid is not the payer for this episode of care.
- 2. Enter NA:
 - if the patient does not have Medicaid or
 - · Medicaid is pending
- 3. Update patient tracking sheet when changes occur during the episode.

M0066	Birth Date: / / month day year	M0066
Item Int	ntent	

Specifies the birth date of the patient, including month, day, and four digits for the year.

Time Points Item(s)

SOC

Optimal Question

• What is your birth date?

Optimal Strategy/Technique

 Check the Common Working File and verify with the patient's legal photo ID, driver's license or other legal form of documentation.

- 1. Note if patient is close to turning 18 or 65 as patient may require another collection of OASIS data for the new payer.
- 2. If I.D. and birth date obtained from the Medicare Common Working File don't match, inform the patient and create a resolution.

M0069	Gender: ☐ 1 – Male ☐ 2 – Female	M00
ltem In	ntent	
Specifi	fies the gender of the patient.	
Time F	Points Item(s)	
SOC		
Optimal	Il Question	
None	ne	
Optimal	ll Strategy/Technique	
• (Check patient's legal photo ID.	
Tips		
1. (Gender is legally established at birth and when changed requires a legal process to cre	eate a new

birth certificate.

M0080 Discipline of Person Completing Assessment:

□ 1 - RN □ 2 - PT □ 3 - SLP/ST □ 4 - OT

M0080

Item Intent

Specifies the discipline of the clinician completing the comprehensive assessment during an actual visit to the patient's home at the specified OASIS time points or the clinician reporting the transfer to an inpatient facility or death at home.

Time Points Item(s)

SOC ROC FU TRF DC DAH

Optimal Question

None

Optimal Strategy/Technique

 Consult agency administrative staff if a payer requirement for who may complete the comprehensive assessment is unknown.

Tips

1. The payer source for home health services will determine who can complete the comprehensive assessments. This may be further modified based on the state professional practice acts.

For Medicare:

- Nursing and rehab team members may collaborate regarding interpretation of patient assessment findings but only one person takes responsibility for the complete assessment and documentation on the form.
- When nursing services are ordered at SOC on the initial referral (regardless of when the visit(s) are to occur in the episode), nursing must perform the comprehensive assessment and complete the SOC form.
- Occupational therapy services may not complete SOC assessment.
- At other time points, when there are multiple services involved in care, an RN is not required
 to conduct the comprehensive assessment and the most appropriate of RN, PT, SLP or OT
 may conduct and record the assessment. The discharge assessment is completed by the
 skilled discipline to make the last visit.
- Refer to Medicare Condition of Participation: Comprehensive assessment regulation 42CFR 484.55.

M0090 Date Assessment Completed:

l: ____/__ /___ __ __ __ __ month day year

M0090

Item Intent

Specifies the actual date the assessment is completed.

Time Points Item(s)

SOC ROC FU TRF DC DAH

Optimal Question

• When did I have all the information I needed to complete the comprehensive assessment?

Optimal Strategy/Technique

When collaboration with the physician and other agency staff is necessary, complete the
comprehensive assessment in the shortest amount of time and within the timeframe allowed for
each time point.

Tips

1. Make every effort to obtain collaborative information so that the assessment can be completed the same day the visit is made.

Note: Some of the processes to be reported on in subsequent OASIS items may take additional time due to the need for communication and collaboration with the physician and/or other agency staff. Be as efficient as possible with the goal of completing the assessment in the allotted time frames. See below.

- 2. Usually the date the assessment is completed is associated with a visit. However, if the clinician needs to follow-up off site with the patient's family or physician in order to complete any clinical data items, or confer with agency therapists to answer M2200 or confer with other agency staff for help with selecting diagnoses or doing a drug regimen review, M0090 will reflect the date the missing information is obtained by the assessing clinician which now completes the assessment.
- 3. If the *original assessing clinician* gathers additional information during the SOC 5 day assessment time frame that would change a M item response, the M0090 date would be changed to reflect the date the information was gathered and the change was made.
- 4. If agency policy allows for more than one visit to complete the assessment, M0090 will reflect the date the same clinician finishes gathering the clinical assessment data.
- 5. Agency internal supervisory review of the document for completeness and accuracy, assignment of ICD-9-CM code to the diagnostic statements or an agency policy that allows assessment findings to be documented on a subsequent day would not affect the date the assessment is completed as the actual assessment and data collection is conducted and obtained prior to the internal review and documentation process.
- 6. The SOC (M0100 RFA 1), ROC (M0100 RFA 3), follow-up (M0100 RFA 4, 5) and discharge assessments (M0100 RFA 9) must be completed through a face to face encounter with the patient.
- 7. If the discharge unexpectedly occurs without opportunity or orders for a final visit refer to the clinical record and documentation of the last visit made by a clinician qualified to complete the comprehensive assessment (RN, PT, SLP, and OT). That clinician should complete the discharge assessment reporting the patient's health status at the time of that visit and record the date the findings are documented.
- 8. For a transfer to an inpatient facility or death at home assessments (M0100 RFA 6, 7, and 8) record the date the agency completes the data collection after learning of the event. These assessments do not require an actual face to face encounter to complete.

CONTINUED

- 9. The Medicare Conditions of Participation require the comprehensive assessments to be completed in the following time frame:
 - i. SOC (M0100 RFA 1) within 5 calendar days after the SOC (SOC = Day 0)
 - ii. ROC (M0100 RFA 3) within 2 calendar days of facility discharge date or knowledge of patient return to home
 - iii. Follow up Recert (M0100 RFA 4) last 5 days of every 60 days
 - iv. Other Follow up (SCIC M0100 RFA 5) within 2 calendar days of identification of Significant Change in Condition
 - v. Transfer to inpatient facility with or without discharge from the agency (M0100 RFA 6, 7) within 2 calendar days of discharge/transfer/death date (M0906) or knowledge of qualifying transfer
 - vi. Death at home (M0100 RFA 8) within 2 calendar days of disch/transfer/death date
 - vii. Discharged from agency not to inpatient facility (M0100 RFA 9) within 2 calendar days of disch/transfer/death date
- Refer to OASIS Reference Sheet Version July 19, 2006, https://www.qtso.com/download/hha/OASIS_Ref_Sheet.07.19.06.pdf

M0100 This Assessment is Currently Being Completed for the Following Reason: Start/Resumption of Care ☐ 1 – Start of care—further visits planned ☐ 3 – Resumption of care (after inpatient stay) Follow-Up 4 - Recertification (follow-up) reassessment **[Go to M0110]** ☐ 5 – Other follow-up **[Go to M0110]** Transfer to an Inpatient Facility ☐ 6 - Transferred to an inpatient facility—patient not discharged from agency [Go to M1040] ☐ 7 - Transferred to an inpatient facility—patient discharged from agency [Go to M1040] <u>Discharge from Agency — Not to an Inpatient Facility</u> ☐ 8 – Death at home [Go to M0906] ☐ 9 – Discharge from agency [Go to M1032] Item Intent Identifies the "time points" - reason why the assessment data are being collected and reported. Accurate recording of this response is important as the logic in the data reporting software will accept or reject certain data according to the specific response that has been selected for this item. Time Points Item(s) SOC ROC FU TRF DC DAH **Optimal Question** What is this patient's home care history? Is this a new patient or does this patient have a current open episode? **Optimal Strategy/Technique** Consult with administrative and/or billing staff to determine if this assessment marks the beginning of a home care encounter (SOC) or this is the continuation of a current home care episode (all other reasons for assessment). Tips 1. Mark only one response. 2. Response 1: This is the start of care comprehensive assessment. A home care plan of care is being established and further visits are planned.* Exception: Select this response anytime an initial HHPPS code is required by any payer whether or not further services are received. If only one visit has been made and the agency will bill Medicare for the visit, the discharge OASIS assessment is not required by regulation.

- 3. Response 3: This comprehensive assessment is conducted when the patient resumes care following an inpatient admission and stay of 24 hours or longer for reasons other than diagnostic tests.*
 - Note: Update patient tracking sheet.
- 4. Response 4: This comprehensive assessment is conducted during the last 5 days of the episode.*
- 5. Response 5: This comprehensive assessment is conducted due to a significant change (major decline or improvement) in patient condition not anticipated in the home health plan of care at a time other than during the last five days of the episode. The circumstances defining a major decline or improvement are contained in agency policy. This assessment is done to update the patient's plan of care.*

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- 6. Response 6: Record data regarding the patient's admission to an inpatient facility for 24 hours or longer for reasons other than diagnostic testing. The patient is expected to resume agency care and is not discharged from the agency.**
- 7. Response 7: Record data regarding the patient's admission to an inpatient facility for 24 hours or longer for reasons other than diagnostic testing. The patient is discharged from the agency.**
- 8. Response 8: Report data regarding patient's death when death occurs at home, during transportation to an inpatient facility or when in any department of the facility prior to treatment and actual inpatient admission.**
- 9. Response 9: This comprehensive assessment is conducted at the patient's discharge from the agency when the discharge results in a transfer of the patient from one agency to another or is *not* a result of the patient's admission to an inpatient facility or death.*
 - Exception: A visit is not required when a patient is unexpectedly discharged, such as: the patient refuses, the physician orders a discharge without another visit, patient unexpectedly moves, or safety of the staff is in jeopardy. The clinician who made the last visit and qualifies to complete an assessment (RN, PT, SLP, OT not LPN/LVN, PTA, OTA, HHA) should complete the assessment to best of their ability describing the patient's health status at the time of the most recent visit.
- In special circumstances, consult OASIS Management for Single Visit at Start of Care or Resumption of Care http://www.qtso.com/hhadownload.html and OASIS Considerations for Medicare PPS Patients (Revised July 2009) www.cms.hhs.gov/oasis/downloads/OASISConsiderationsForPPS.pdf

^{*}Requires face to face patient contact on home visit for completion.

^{**}Does not require home visit for completion.

M0102 Date of Physician-ordered Start of Care (Resumption of Care): If the physician indicated a specific start of care (resumption of care) date when the patient was referred for home health services, record the date specified. ____/__/___(Go to M0110, if date entered) month / day / year NA – No specific SOC date ordered by physician (or physician designee) Item Intent Specifies the date that home care services are ordered to begin, if the date was specified by the physician. The item refers to the order to start home care services (i.e., provide the first covered service), regardless of the type of services ordered (e.g., therapy only).

Time Points Item(s)

SOC ROC

Optimal Question

 Did the physician order home care services or medical treatment to begin/resume on a specific date? If yes, what is that date?

Optimal Strategy/Technique

Intake staff or designee to record physician order specifying date when applicable. Record order in
a consistent spot on the clinical record for access by the assessing clinician and communicate with
person responsible for scheduling visits.

- 1. Record the physician ordered SOC/ROC date when applicable.
- 2. If the patient condition changes and the physician changes the specific date to begin home care services or treatment, record the most recent date.
- If agency staff become aware that the patient condition and circumstance changes and the patient needs an earlier or delayed SOC/ROC visit, contact the physician and request a new order.
 Document the circumstances and record the revised order date.
- 4. Select NA if the physician does not order a specific date to start/resume home care services or treatment or provides a date range (e.g., week of Jan 3, etc.).
- 5. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date.
- 6. This item is used to report the quality measure for timely initiation of care and compliance with this Medicare Conditions of Participation 42 CFR 484.55(a) Initial assessment visit. http://www.access.gpo.gov/nara/cfr/waisidx 99/42cfr484 99.html

M0104 Date of Referral: Indicate the date that the written or documented referral for initiation or resumption of care was received by the HHA.



Item Intent

Specifies the referral date, which is the most recent date that verbal, written, or electronic authorization to begin home care was received by the home health agency.

Time Points Item(s)

SOC ROC

Optimal Question

None

Optimal Strategy/Technique

• Intake staff or designee to record date of the most recent notification of the physician order to provide home care services and treatment. Place it in a consistent spot on the clinical record and communicate with person responsible for scheduling visits.

Tips

- 1. In the absence of a physician request to begin/resume home care services or treatment on a specific date, record the date the agency personnel received the most recent revised/updated referral information for home care services from the physician or person acting on his behalf.
- The initial assessment visit must be conducted either within 48 hours of referral, or within 48 hours
 of the patient's return home, or on the physician-ordered start of care date. This item is used to
 report the quality measure for timely initiation of care and compliance with Medicare Conditions of
 Participation 42 CFR 484.55(a) Initial assessment visit.
 http://www.access.gpo.gov/nara/cfr/waisidx_99/42cfr484_99.html.

M0104 Process Implications: Timely initiation of care

Clinical Recommendations

- Communicate with intake staff regarding most recent referral date.
- If date pre-populated by software, verify accuracy.
- Revise date if physician advises/approves of changes based on patient condition or request.
- Conduct the SOC/ROC visit as planned within the approved time frame.
- Notify the supervisor if it cannot occur and include documentation as to why it cannot occur.

Operational Recommendations

- Develop/ensure process and assign responsibility for recording referral date in a consistent place, available to all staff who conduct SOC/ROC assessments.
- Determine if process is different on weekends.
- Include who, how and in what circumstances changes can be made.
- Ensure physician is notified when patient or agency circumstances will create noncompliance with Medicare COP for initial assessment.

Optimal Question

• When was the last time you had home health services? When was the last time a nurse or therapist visited you in your home?

Optimal Strategy/Technique

 Consult with office based staff to check agency records for the patient's recent history with home health. Check the Medicare system, Health Insurance Query for Home Health (HIQH) for this information at the time of referral.

Tips

- 1. Select "Early" if the Medicare payment episode is the only episode OR the first or second episode in a current sequence of adjacent Medicare home health payment episodes.
- 2. Select "Later" if the Medicare payment episode is the third or higher in the current sequence of adjacent Medicare home health payment episodes.
- 3. Select "UK Unknown" response if the placement of this payment episode in the sequence of adjacent episodes is unknown. This will have the same effect as selecting the "Early" response when calculating reimbursement.
- 4. At ROC, this response does not usually affect payment and "unknown" could serve as an appropriate response. However, if the ROC also serves as a recertification assessment when the patient is discharged from an inpatient facility in the last five days of the certification period, the response of early or late should describe the upcoming episode in order to obtain accurate payment.
- 5. Enter "NA" for a non Medicare FFS payer unless the payer requires a case mix code for billing purposes (a "HHPPS" code).
- 6. The Medicare home health payment episode ordinarily comprises 60 days beginning with the start of care date or 60 days beginning with the recertification date. There can be a gap of up to 60 days between episodes in the same sequence, counting from the last day of one episode until the first day of the next. A sequence of adjacent Medicare payment episodes continues as long as there is no 60-day gap, even if Medicare episodes are provided by different home health agencies.
- 7. "Adjacent" means that there was no gap between Medicare-covered episodes of more than 60 days.
- 8. Low utilization payment adjustment (LUPA) episodes (less than 5 total visits) are counted as an episode.

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- 9. Episodes where Medicare fee-for-service is not the payer (such as HMO, Medicaid, or private pay) do NOT count as part of an adjacent episode sequence and are counted as *gap* days. If the period of service with those payers is 60 days or more, the next Medicare home health payment episode would begin a new sequence. The 60-day *gap* is counted from the end of the Medicare payment episode, NOT from the date of the last visit or discharge, which can occur earlier. If the episode is ended by an intervening event that causes it to be paid as a partial episode payment [PEP] adjustment, then the last visit date is the end of the episode.
- 10. The Medicare computers will "correct" this item at the time the final bill is submitted, or anytime thereafter additional input to the Medicare system indicates the selection was incorrect. The agency "correction" of this OASIS item is optional.

M0140	Race/Ethnicity: (Mark all that apply.) 1 - American Indian or Alaska Native 2 - Asian 3 - Black or African-American 4 - Hispanic or Latino 5 - Native Hawaiian or Pacific Islander 6 - White
ltem lı	ntent
patient	es the racial/ethnic groups or populations with which the patient is affiliated, as identified by the or caregiver. Office of Management and Budget (OMB) regulations state that "unknown" is not issible response for this item. The major purpose of this item is to track health disparities.
Time I	Points Item(s)
Optimal	Question
None	
Optimal	Strategy/Technique
	Show the patient the list of choices from the form and ask them to choose which group they dentify with. Read choices aloud to patients who cannot read because of visual or literacy issues.
	Assure patient that all information is private and protected as disclosed to them through the SOC process.
Tips	

2. Observation without confirmation from the patient is not an accurate strategy.

1. Mark all that apply.

M015	Current Payment Sources for Home Care: (Mark all that apply.)
	 □ 0 - None; no charge for current services □ 1 - Medicare (traditional fee-for-service) □ 2 - Medicare (HMO/managed care/Advantage plan) □ 3 - Medicaid (traditional fee-for-service) □ 4 - Medicaid (HMO/managed care) □ 5 - Workers' compensation □ 6 - Title programs (e.g., Title III, V, or XX) □ 7 - Other government (e.g., TriCare, VA, etc.) □ 8 - Private insurance □ 9 - Private HMO/managed care □ 10 - Self-pay □ 11 - Other (specify) □ UK Unknown
Item	Intent
	tem is limited to identifying payers to which any services provided during this home care episode ncluded on the plan of care will be billed by your home health agency.
Time	Points Item(s)
SOC	
Optima	al Question
•	What insurance do you expect will pay for the home care services being provided to you?
•	What health insurance do you have and are you or your partner/spouse still working?
Optima	al Strategy/Technique
•	Complete Medicare secondary payer questionnaire (MSP).
Tips	
1.	Select responses for payers verified to pay for home care services. Do not include pending payer sources.
2.	Be aware of eligibility and coverage requirements for each payer.
3.	Obtain authorizations as needed.
4.	When completing MSP, collect as much insurance information applicable to the patient situation as possible, e.g. name and policy numbers for group health insurance, homeowners insurance, motor vehicle insurance, details regarding where/how injury occurred and contacts for liability issues, etc.

5. Update patient tracking sheet when changes occur during the episode.

M1000 From which of the following Inpatient **Facilities** was the patient discharged during the past 14 days? (Mark all that apply.) ☐ 1 - Long-term nursing facility (NF) 2 - Skilled nursing facility (SNF / TCU) 3 - Short-stay acute hospital 4 - Long-term care hospital (LTCH) 5 - Inpatient rehabilitation hospital or unit (IRF) 6 - Psychiatric hospital or unit 7 - Other (specify) ☐ NA - Patient was not discharged from an inpatient facility **[Go to M1016]** Item Intent Identifies whether the patient has been discharged from an inpatient facility within the 14 days (two-week period) immediately preceding the start of care/resumption of care. The purpose of this item is to establish the patient's recent health care history before formulating the plan of care. This determination must be made with sufficient accuracy to allow appropriate care planning. For example, the amount and types of rehabilitation treatment the patient has received and the type of institution that delivered the treatment are important to know when developing the home health plan of care. Time Points Item(s) SOC ROC **Optimal Question** Were you in a hospital or other care facility in the last 14 days? While you were in the hospital, were you moved to another room or floor? What was the name of the hospital or care facility? Did Medicare pay for your treatment? **OR** ask referral source:

Was the patient receiving Medicare Part A benefits from any inpatient facility in the past 14 days?

Optimal Strategy/Technique

- Intake or other personnel to collect inpatient stay information at time of referral.
- Contact facility billing department if needed to determine if Medicare Part A benefits paid for any services in the last 14 days.
- Create a file of information identifying local inpatient facilities licensed as short stay acute
 hospitals, long term hospitals, SNF, and Rehab facilities. Identify which hospitals have swing beds,
 separately licensed skilled nursing facility beds and separately licensed rehabilitation beds.
 Distribute information to clinical assessors.

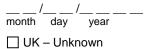
Tips

- 1. Intake staff is the most knowledgeable about facility types and licensure.
- 2. Determine "past 14 days" by looking at a calendar. Determine the day of the week for SOC/ROC. Look back to the same day 2 weeks previous. Discharges occurring on or during these days are "the past 14 days."
- Discharge from inpatient facility in the last 14 days is not always obvious especially when referrals come directly from the physician's office after post hospital follow up appointment.

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- 4. Hospitals can have "swing beds" (frequently in rural areas), separately licensed skilled nursing facility beds and separately licensed rehabilitation beds within their walls. They may also have freestanding SNF and rehabilitation facilities on or off campus.
- 5. A skilled nursing facility can have Medicare A beds, beds not paid for by Medicare A (long term) and separately licensed rehabilitation beds.
- 6. Response 1: Long term nursing facility- circumstance when the patient was discharged from a Medicare-certified skilled nursing facility, but did not receive care under the Medicare Part A benefit in the 14 days prior to home health care.
- 7. Response 2: Skilled nursing facility SNF/TCU is a Medicare-certified nursing facility where the patient received a skilled level of care under the Medicare Part A benefit or Transitional Care Unit within a Medicare certified nursing facility.
- 8. Select response 2 if all 3 of these questions are answered "yes":
 - Was the patient discharged from a Medicare-certified skilled nursing facility? If so, then:
 - While in the skilled nursing facility was the patient receiving skilled care under the Medicare Part A benefit? If so, then:
 - Was the patient receiving skilled care under the Medicare Part A benefit during the 14 days prior to admission to home health care?
- 9. Response 3: (previously known as Acute Care Hospitals). Short-stay acute hospital is a state licensing term. Most hospitalizations are from these; Medicare reimburses these facilities per an Inpatient Prospective Payment System (IPPS) via DRG.
- 10. Response 4: Long term care hospital is a state licensing term for hospitals whose average length of stay is 25 days or more.
- 11. Response 5: Inpatient rehabilitation hospital or unit (IRF) means a freestanding rehab hospital or a rehabilitation bed in a rehabilitation distinct part unit of a general acute care hospital.
- 12. Response 7: Other includes Intermediate care facilities for the mentally retarded (ICF/MR).
- 13. If patient has been discharged from a swing-bed hospital, determine whether the patient was occupying a designated hospital bed (response 3), a skilled nursing bed under Medicare Part A (response 2), or a nursing bed at a lower level of care (response 1).
- 14. Failure to select discharges from **ALL** inpatient stays within the past 14 days will affect the risk adjustment when determining many patient outcomes.

M1005 Inpatient Discharge Date (most recent):





Item Intent

Identifies the date of the <u>most recent</u> discharge from an inpatient facility (within last 14 days). (Past 14 days encompasses the two-week period immediately preceding the start/resumption of care.)

Time Points Item(s)

SOC ROC

Optimal Question

- Were you a patient in a hospital or care facility recently?
- When did you leave there?

Optimal Strategy/Technique

 Ask to see copy of facility D/C instructions to validate D/C date. Intake or other office personnel to contact facility and verify discharge date.

- 1. Review events leading to current home care episode with the patient. Intake staff not always aware of recent discharge from an inpatient facility in the past 14 days if the referral came from a physician's office.
- 2. Determine "past 14 days" by looking at a calendar. Determine the day of the week for SOC/ROC. Look back to the same day 2 weeks previous. Inpatient stays with facility discharges occurring on or during these days are "the past 14 days."
- 3. If patient discharged from more than one inpatient facility in past 14 days, record date of *most recent* discharge.

M1010 List each Inpatient Diagnosis and ICD-9-CM code at the level of highest specificity for only those conditions treated during an inpatient stay within the last 14 days (no E-codes, or V-codes):



Inpatient Facility Diagnosis	ICD-9-CM Code
a	
b	
C	·
d	
e	·
f	·

Item Intent

Identifies diagnosis(es) for which patient was receiving treatment in an inpatient facility within the past 14 days. This list of diagnoses is intended to include only those diagnoses that required treatment during the inpatient stay and may or may not correspond with the hospital admitting diagnosis. This expanded list allows for a more comprehensive picture of the patient's condition prior to the initiation or resumption of home care.

Time Points Item(s)

SOC ROC

Optimal Question

• Please describe what happened with your care while you were in the hospital or care facility? What did the doctor do for you? What kind of treatments did you have (e,g, surgery, oxygen, wound care, frequent blood sugars and insulin, therapy, etc.)?

Optimal Strategy/Technique

 Intake or other office personnel to contact referral source, physician, and/or facility staff for clinical information related to treatment while an inpatient. Request H & P and discharge summary.

- Determine "past 14 days" by looking at a calendar. Determine the day of the week for SOC/ROC. Look back to the same day 2 weeks previous. Inpatient stays with facility discharges occurring on or between these days are "the past 14 days."
- 2. List up to six conditions/diseases/injuries that were treated during the inpatient stay. They could be new or exacerbations of comorbidities. Changes in medications and facility discharge instructions could help identify the conditions that were treated.
- 3. Do not list symptoms when the condition/disease is known.
- 4. Do not list V or E codes, list the underlying condition.
- 5. This item identifies acute conditions for risk adjustment of patient outcome measures.

M1012 List each Inpatient Procedure and the associated ICD-9-CM procedure code relevant to the plan of care. Inpatient Procedure Procedure Code ☐ NA – Not Applicable UK – Unknown Item Intent Identifies medical procedures that the patient received during an inpatient facility stay within the past 14 days that are relevant to the home health plan of care. This item is intended to allow for a more comprehensive picture of the patient's condition prior to the initiation of home care. Time Points Item(s) SOC ROC **Optimal Question** Did you have any procedures/surgery recently? When and where did they take place? Optimal Strategy/Technique Intake or other office personnel to contact referral source, physician, and/or facility staff for clinical information related to treatment while an inpatient. Request H & P and discharge summary. **Tips** 1. List medical procedures the patient received during an inpatient stay that are relevant to the home health plan of care if the patient was discharged from the inpatient facility in the past 14 days. The procedures could have occurred at any time during the eligible inpatient facility stay.

- 2. Determine "past 14 days" by looking at a calendar. Identify the day of the week for SOC/ROC. Look back to the same day 2 weeks previous. Facility discharges occurring on or between these days are in "the past 14 days."
- 3. Ask to see pt discharge instructions.
- 4. Seek assistance from agency "coder" regarding ICD 9 CM codes for any relevant medical procedure.
- 5. Information is used for risk adjustment of patient outcome measures.

M1016 Diagnoses Requiring Medical or Treatment Regimen Change Within

Past 14 Days: List the patient's Medical Diagnoses and ICD-9-CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen within the past 14 days (no surgical, E-codes, or V-codes):

7		
	M1016	
	IAITOTO	
		J

	Changed Medical Regimen Diagnosis	ICD-9-CM Code
a.	a	
b.	b	··
c.	С	··
d.	d	
e.	e	··
f.	f	· _ · _
	☐ NA – Not Applicable (no medical or treatment	regimen changes within the past 14 days)

Item Intent

Identifies if any change has occurred to the patient's treatment regimen, health care services, or medications within the past 14 days. The purpose of this question is to help identify the patient's recent history by identifying new diagnoses or diagnoses that have exacerbated over the past 2 weeks. This information helps the clinician develop an appropriate plan of care, since patients who have recent changes in treatment plans have a higher risk of becoming unstable.

Time Points Item(s)

SOC ROC

Optimal Question

- When was the last time the doctor made any changes in your medications or treatments (wound care, diet, pain management, activity, therapy, etc.)?
- What symptoms did you have, what was happening to you that caused your doctor to order home care?

Optimal Strategy/Technique

- Investigate with all available resources to determine what changes have occurred to the patient's treatment regimen, health care services (SN, PT, OT, SLP), or medications within the past 14 days. Identify the associated conditions/diagnoses that caused the change. Seek guidance from agency "coding expert" for corresponding ICD-9 CM codes.
- At ROC, also review clinical record for relevant changes.

- Referral and admission to home care does not "count" as a medical or treatment regimen change of itself.
- 2. At ROC, physical therapy (or any other service) ordered at SOC and then discontinued during the past 14 days qualifies as a medical/treatment regimen change.
- 3. Determine "past 14 days" by looking at a calendar. Determine the day of the week for SOC/ROC. Look back to the same day 2 weeks previous. A treatment change occurring on or between these dates qualifies as occurring within the past 14 days.
- 4. Notice dates on medication bottles to help determine new or changed medications and link to associated condition/diagnosis.

M1018 Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days: If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions that existed prior to the inpatient stay or change in medical or treatment regimen. (Mark all that apply.) ☐ 1 - Urinary incontinence ☐ 2 - Indwelling/suprapubic catheter 3 - Intractable pain 4 - Impaired decision-making 5 - Disruptive or socially inappropriate behavior 6 - Memory loss to the extent that supervision required 7 - None of the above ☐ NA - No inpatient facility discharge <u>and</u> no change in medical or treatment regimen in past 14 days ☐ UK – Unknown Item Intent Identifies existence of condition(s) prior to medical regimen change or inpatient stay within past 14 days. This information is important for care planning and setting goals. Time Points Item(s) SOC ROC **Optimal Question** How long have you had trouble with ...? Ask the patient/caregiver about each item listed in language appropriate to the patient/caregiver understanding. Optimal Strategy/Technique

Tips

1. If there was an inpatient facility discharge **or** medical/treatment regimen change that occurred in the past 14 days, this item identifies "less acute" or "chronic" conditions that existed for the patient **prior** to the facility stay or treatment change.

Use all available resources (e.g. referral information, patient and caregiver reports, etc.) to determine if any of these conditions were present **prior to** the inpatient stay or change in medical

- Determine "past 14 days" by looking at a calendar. Determine the day of the week for SOC/ROC.
 Look back to the same day 2 weeks previous. A condition that existed prior to a change in medical
 treatment or a facility stay with discharge that occurred on or between these days are "the past 14
 days."
- 3. Select "NA" **only** when **both** conditions are true: there was no inpatient facility discharge <u>and</u> no change in medical or treatment regimen in past 14 days.
- 4. These items affect risk adjustment of patient outcomes.

or treatment regimen which occurred in the past 14 days.

M1020/1022/1024 Diagnoses, Symptom Control, and Payment Diagnoses: List

each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-CM code at the level of highest specificity (no surgical/procedure codes) (Column 2). Diagnoses are listed in the order that best reflect the seriousness of each condition and support the disciplines and services provided. Rate the degree of symptom control for each condition (Column 2). Choose one value that represents the degree of symptom control appropriate for each diagnosis: V-codes (for M1020 or M1022) or E-codes (for M1022 only) may be used. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V-code is reported in place of a case mix diagnosis, then optional item M1024 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare PPS case mix group. Do not assign symptom control ratings for V- or E-codes.

M1020/ 1022/ 1024

Code each row according to the following directions for each column:

Column 1: Enter the description of the diagnosis.

Column 2: Enter the ICD-9-CM code for the diagnosis described in Column 1;

Rate the degree of symptom control for the condition listed in Column 1 using the following scale:

- 0 Asymptomatic, no treatment needed at this time
- 1 Symptoms well controlled with current therapy
- 2 Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring
- 3 Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring
 - 4 Symptoms poorly controlled; history of re-hospitalizations

Note that in Column 2 the rating for symptom control of each diagnosis should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.

Column 3: (OPTIONAL) If a V-code is assigned to any row in Column 2, in place of a case mix diagnosis, it may be necessary to complete optional item M1024 Payment Diagnoses (Columns 3 and 4). Refer to Appendix D for additional instruction related to the coding of M1024.

Column 4: (OPTIONAL) If a V-code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD-9-CM coding guidelines, enter the diagnosis descriptions and the ICD-9-CM codes in the same row in Columns 3 and 4. For example, if the case mix diagnosis is a manifestation code, record the diagnosis description and ICD-9-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(M1020) Primary Diagnosis	& (M1022) Other Diagnoses	(M1024) Payment Diagnoses (OPTIONAL)		
Column 1	Column 2	Column 3	Column 4	
Assigning or Coding Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.)	ICD-9-C M and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	Complete if a V-code is assigned under certain circumstances to Column 2 in place of a case mix diagnosis**.	Complete only if the V-code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).	
Description	ICD-9-C M / Symptom Control Rating	Description/ ICD-9-C M	Description/ ICD-9-C M	
(M1020) Primary Diagnosis a	(V-codes are allowed) a. () □ 0 □ 1 □ 2 □ 3 □ 4	(V- or E-codes are NOT allowed) a. ()	(V- or E-codes are NOT allowed) a. ()	
(M1022) Other Diagnoses	(V- or E-codes are allowed)	(V- or E-codes are NOT allowed)	(V- or E-codes are NOT allowed)	
b	□ 0 □ 1 □2 □3 □ 4	b. ()	b. ()	
c	c. ()	c. ()	c. ()	
d	d. ()	d. ()	d. ()	
e	e. ()	e. ()	e. ()	
f	f. ()	f. ()	f. ()	

Item Intent

The intent of this item is to accurately code each diagnosis in compliance with Medicare's rules and regulations for coverage and payment. CMS expects HHAs to understand each patient's specific clinical status before selecting and assigning each diagnosis. Each patient's overall medical condition and care needs must be comprehensively assessed **BEFORE** the HHA Identifies and assigns each diagnosis for which the patient is receiving home care. Each diagnosis (other than an E-code) must comply with the "Criteria for OASIS Diagnosis Reporting." (See Appendix D – if a patient has a resolved condition that has no impact on the patient's current plan of care, then the condition does not meet the criteria for a home health diagnosis and should not be coded.) The primary diagnosis (M1020) should be the diagnosis most related to the patient's current plan of care, the most acute diagnosis and, therefore, the chief reason for providing home care.

Secondary diagnoses in M1022 are defined as "all conditions that coexisted at the time the plan of care was established, or which developed subsequently, or affect the treatment or care." In general, M1022 should include not only conditions actively addressed in the patient's plan of care but also any comorbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself. Ensure that the secondary diagnoses assigned to M1022 are listed in the order to best reflect the seriousness of the patient's condition and justify the disciplines and services provided. Agencies should avoid listing diagnoses that are of mere historical interest and without impact on patient progress or outcome. The diagnosis may or may not be related to a patient's recent hospital stay but must relate to the services rendered by the HHA. Skilled services (skilled nursing, physical, occupational, and speech language pathology) are used in judging the relevancy of a diagnosis to the plan of care and to the OASIS.

The order that secondary diagnoses are entered should be determined by the degree that they impact the patient's health and need for home health care, rather than the degree of symptom control. For example, if a patient is receiving home health care for Type 2 diabetes that is "controlled with difficulty," this diagnosis would be listed above a diagnosis of a fungal infection of a toenail that is receiving treatment, even if the fungal infection is "poorly controlled."

A case-mix diagnosis (Column 3) is a diagnosis that gives a patient a score for Medicare Home Health PPS case-mix group assignment. A case mix diagnosis may be the primary diagnosis, "other" diagnosis, or a manifestation associated with a primary or other diagnosis. Each diagnosis listed in M1020 and M1022 should be supported by the patient's medical record documentation (i.e., the patient's Plan of Care is in compliance with 42 CFR 484.18(a)). The list of case mix diagnosis codes is included in the HH PPS Grouper documentation available on the CMS web site (see Chapter 5 of this manual for a link to this website).

Time Points Item(s)

SOC ROC FU

Optimal Question(s)

- Primary Diagnosis: Considering all disciplines, what does the team plan to do for the patient?
 What is the main focus of care and the chief reason for providing care?
- Secondary Diagnoses: Considering all disciplines, what does the team plan to do for the patient? What diagnoses are addressed by the home health plan of care or have the potential to affect the plan of care, affect progress and rehabilitation potential and/or justify the services provided?
- Payment Diagnoses: When there is a V code as a primary or secondary diagnosis, what is the
 underlying condition represented by the V-code? Name that numeric medical diagnosis that is
 being replaced by the V code.

Optimal Strategy/Technique

- Determine diagnoses after completion of the comprehensive assessment.
- Determine the patient's needs; formulate the interventions and goals for the home health plan of care and identify a list of diagnoses that will be addressed by those interventions and goals.
- Considering all services, identify the most acute diagnosis that is driving the home health plan of care/485 for the primary diagnosis and the other diagnoses requiring skilled intervention or have the potential to affect the patient's progress and rehabilitative potential or justify the planned services. Confirm with the physician.

Tips

- 1. A comprehensive listing of applicable diagnoses describes the patient's current health status and helps to establish the need for skilled services and the medical complexity of the patient. These are also risk factors which may affect the calculation of patient outcome measures.
- 2. Use all available resources, referral information, list of medications, reports of the patient and family to determine applicable diagnoses and confirm with the physician.
- 3. The assessing clinician must:
 - determine the primary and secondary diagnoses
 - assign corresponding symptom control rating
 - list/sequence the diagnoses in order of their seriousness, by the degree they impact the patient's health and need for home health care
- 4. The assessing clinician may consult coding specialists within the agency:
 - for application of the ICD-9-CM codes
 - compliance with sequencing rules
 - to determine if use of V-code in M1020 is eligible for the use of the optional numeric diagnosis code in M1024
- 5. The diagnoses reported in OASIS items M1020/M1022, on the Home Health Agency Plan of Care and the Medicare claim must match. For more information refer to Chapter 10, section 40.2 of the Medicare Claims Processing Manual http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf
- 6. Staff other than the assessing clinician may record the ICD-9-CM code applicable to the diagnosis statement in accordance with agency policies and procedures.
- 7. Recommendations for changes to the primary diagnosis, the addition of other pertinent diagnoses and the need to change their sequence during the agency's internal review process can only be made after agreement by the assessing clinician and in accordance with the agency's policy for correcting medical records.
- 8. Eligible diagnosis codes are considered for risk adjustment calculation.
- 9. Follow ICD-9-CM coding guidelines, http://www.cdc.gov/nchs/icd/icd9cm.htm
- 10. Use *current* coding books.
- 11. For more information see OASIS C Guidance Manual and Appendix D. Go to http://www.cms.hhs.gov/HomeHealthQualityInits/ and click on OASIS User Manuals.

Primary Diagnosis

- Diagnosis most related to the current plan of care developed by the agency.
- Condition that represents the most acute condition and most intensive services.
- Might not be related to the reason for hospitalization but relates to the services provided by the agency.
- May be a V-code.

Secondary Diagnoses:

- Other conditions addressed by the plan of care.
- Conditions that coexist at the time the plan of care is established or develop subsequently (added to the plan of care at the time of recertification.
- Comorbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself.
- Justify disciplines and services rendered.
- May be described as a V or E code.
- Avoid listing diagnoses of mere historical interest.

Symptom Control Ratings:

- Evaluate to what extent presenting symptoms are controlled by current treatments and frequency of contacts with health care providers.
- Symptom control ratings do not apply to V-codes and E-codes.
 - 0. Asymptomatic; no treatment needed at this time. e.g., Condition requires no treatment or medication.
 - Symptoms well controlled with current therapy.
 e.g., Current treatment, medications, services for this condition has not required change in recent past.
 - 2. Symptoms controlled with difficulty affecting daily functioning and needs ongoing monitoring.
 - e.g., Condition new or in exacerbation. Currently stable treatment regimen but new/changed enough to require observation and assessment.
 - Symptoms poorly controlled; needs frequent adjustment in treatment and dose monitoring.
 e.g., Condition unstable requiring close observation and assessment. Recent history of
 treatment or medication changes and more changes anticipated. Requires close
 monitoring to achieve therapeutic levels.
 - Symptoms poorly controlled; history of re-hospitalizations.
 e.g., Condition significantly unstable. In spite of treatment or medication changes, history of hospitalizations in past year.

Payment Diagnoses

- Although completion of M1024 is optional, it is related to payment and risk adjustment. Carefully consider decision not to complete it.
- A case mix diagnosis provides a score for Medicare Home Health PPS case mix group assignment. Explore all V-codes used in M1020/1022 for potential replacement with a Case Mix Diagnosis in M1024 Payment Diagnosis Column 3.
- Complete M1024 with the case mix diagnosis when the case mix diagnosis has been replaced by a V-code:
 - a. to prevent the loss of case mix points from the following groups:
 - i. Diabetes
 - ii. Skin 1--Traumatic Wounds, Burns & Post-Operative Complications
 - iii. Neuro 1 -- Brain Disorders and Paralysis),
 - b. when the V-code is displacing a case mix diagnosis that is inappropriate to report as an underlying or associated code in M1022 per coding guidelines
- Diagnoses designated as case mix can be identified in a current code book.
- When a V-code replaces a case mix code in the primary diagnosis and the case mix code is a combination etiology and manifestation code as identified in the ICD-9-CM code book, then place the etiology code in M1024 Column 3 and the manifestation code in M1024 Column 4 for correct payment.
- For a list of case mix diagnoses: http://www.cms.hhs.gov/HomeHealthPPS/01_overview.asp#TopOfPage

V-codes:

- Assign when a patient with a resolving disease or injury requires specific aftercare of that disease or injury.
- Are less specific to the clinical condition (often describe treatments and encounters or interventions) than numeric diagnosis codes (ones that describe a disease or injury).
- Avoid excessive use.
- Sequencing is discretionary per ICD-9CM Official Guidelines for Coding and Reporting. When not a primary diagnosis, consider placement lower in the diagnosis list to provide space for more serious pertinent diagnoses and comorbidities.

M1030 Therapies the patient receives at home: (Mark all that apply.) 1 - Intravenous or infusion therapy (excludes TPN) 2 - Parenteral nutrition (TPN or lipids) 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal) 4 - None of the Above

Item Intent

Identifies whether the patient is receiving intravenous, parenteral nutrition, or enteral nutrition therapy at home, whether or not the home health agency is administering the therapy. This item is not intended to identify therapies administered in outpatient facilities or by any provider outside the home setting.

Time Points Item(s)

SOC ROC FU

Optimal Question

- Do you receive any medication or food at home that is not taken by mouth?
- Are you getting any IV meds at home or do you have an insulin or pain pump?

Optimal Strategy/Technique

 When inspecting skin, observe for signs of vascular access devices (VAD), gastrostomy sites or other enteral delivery devices.

Tips

- 1. Include all infusion, enteral or parenteral therapies the patient is currently receiving **in his home** regardless of who administers/cares for it.
- Infusion therapy involves a therapeutic drug or solution that is administered via an infusion device, including a needle flush, implanted or external pump, or other infusion device.
- 3. Include:
 - Central line, subcutaneous, epidural, intrathecal infusions, insulin pumps and home dialysis.
 - Intermittent medications, fluids or flushes via IV line (e.g., heparin or saline flush).
 - Enteral nutrition.
 - Therapy initiated at SOC or is a result of SOC assessment and physician orders reflect treatment and start date.
 - Discontinuation of these therapies on day of assessment.

4. Exclude:

- Presence of feeding tube when there is no prescription for therapy which provides nutrition.
- Feeding tube used for medication administration only.
- Feeding tube used for hydration only.
- Flushing feeding tube to keep patent.
- (Flushing of a feeding tube does not provide nutrition and is not considered a therapy.)
- IM or SQ injection given over 10 minutes.
- Medication administered transdermally.
- Infusions or enteral nutrition to be administered when specific parameters are met and the parameters are not met on the day of the assessment.
- Any therapies administered by any health care provider outside the home setting.
- Patient refusal of therapies on the day of assessment.
- Flushing of a venous access device when included as part of parenteral therapy procedure.
- Pedialyte, an oral electrolyte maintenance solution, when administered to prevent dehydration and as such is not designed to act as nutrition.

M1032 Risk for Hospitalization: Which of the following signs or symptoms M1032 characterize this patient as at risk for hospitalization? (Mark all that apply.) ☐ 1 - Recent decline in mental, emotional, or behavioral status 2 - Multiple hospitalizations (2 or more) in the past 12 months 3 - History of falls (2 or more falls - or any fall with an injury - in the past year) ☐ 4 - Taking five or more medications 5 - Frailty indicators, e.g., weight loss, self-reported exhaustion 6 - Other 7 - None of the above Item Intent Identifies patient characteristics that may indicate the patient is at risk for hospitalization in the care provider's professional judgment. Time Points Item(s) SOC ROC **Optimal Question** Are you concerned that you might be admitted to the hospital? Why? Optimal Strategy/Technique Use available resources (e.g. referral information, etc.) and interview patient and caregiver to determine the patient's experience with items listed. Tips 1. Based on all assessment information, use professional judgment to determine which risk factors are present for this patient.

- 2. Use information to create interventions and a plan of care aimed at reducing risk for hospitalization.
- 3. Response 5 Frailty factors could include:
 - the experience of weakness
 - debility
 - slow gait speed, etc.
- 4. Response 6 Other could include:
 - decompensating clinical condition
 - unstable care giving situation
 - inadequate financial resources for food and medication
 - living arrangement, etc.

M1034 **Overall Status:** Which description best fits the patient's overall status? (Check one) 0 - The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient's age). 1 - The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient's age). 2 - The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death. 3 - The patient has serious progressive conditions that could lead to death within a year. ☐ UK - The patient's situation is unknown or unclear. Item Intent Identifies the general potential for health status stabilization, decline, or death in the care provider's professional judgment. Time Points Item(s) SOC ROC **Optimal Question** What is your professional opinion as to how much the patient will recover, improve or decline in health status? **Optimal Strategy/Technique** Consider recent clinical events, the effect on the patient's health status, the impact of co morbidities and his/her current clinical condition. Use your experience and exercise professional judgment to describe your expectation for this patient's recovery.

- 1. Use all available assessment data and professional judgment to determine the patient's general potential for health status stabilization, decline, or death.
- 2. Best answered after all assessment data are collected and evaluated.
- Read all the responses from the bottom up and select the most appropriate response.
- 4. Used in risk adjustment of patient outcomes.

M103	6 Risk Factors, either present or past, likely to affect current health status and/or outcome: (Mark all that apply.)	M1036
	 □ 1 - Smoking □ 2 - Obesity □ 3 - Alcohol dependency □ 4 - Drug dependency □ 5 - None of the above □ UK - Unknown 	
Ident respo	Intent diffies specific factors that may exert a substantial impact on the patient's health status, conse to medical treatment, and ability to recover from current illnesses, in the care provider's essional judgment.	
Time	Points Item(s) ROC	_
Optim	al Question	_
•	Do you smoke?	
•	How often do you use these medications for (pain, sleep, anxiety, etc.)? How long have you been taking them?	
•	Ask probing questions with a non judgmental attitude to determine if medications are no longer being taken for their intended therapeutic purpose.	
•	How much and how often do you drink?	
Optim	al Strategy/Technique	
•	Weigh the patient and observe the environment (e.g. ash trays, bottles, drug paraphernalia) for evidence of current behaviors/risk factors.	
Tips		_
1.	Use judgment in evaluating risks to current health conditions from behaviors that continue or were stopped in the past.	
2.	Consider using BMI to determine obesity. http://www.nhlbisupport.com/bmi/	

M1040 Influenza Vaccine: Did the patient receive the influenza vaccine from your agency for this year's influenza season (October 1 through March 31) during this episode of care? 0 - No 1 - Yes [Go to M1050] NA - Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge) is outside this influenza season. [Go to M1050] Item Intent Identifies whether the patient received an influenza vaccine for the current influenza season from the

Identifies whether the patient received an influenza vaccine for the current influenza season from the home health agency during this episode of care. This item does not assess flu vaccine given by another care provider or provision of the vaccine by your agency prior to the most recent SOC/ROC, as that information will be reported in M1045. Responses to M1040 and M1045 are combined to report the percentage of eligible patients who received influenza immunization for the current flu season.

Time	Points	Item(s)
TRF	DC	

Optimal Question

Did you receive the seasonal flu shot from anyone in this agency? When?

Optimal Strategy/Technique

- Document when and who administered seasonal flu shot in an agency specified and consistent location of the medical record throughout the episode(s) of care.
- Determine dates of quality episode. Check to see that some or all of the quality episode dates fall within the flu season (October 1 through March 31). Identify whether agency staff administered the flu vaccine on a date within the quality episode.

Tips

- 1. Maintain a record of flu and pneumonia vaccines, including the date and which health provider administered, so that it is available for easy retrieval at this time point when a transfer or discharge assessment is completed.
- 2. Determine the quality episode for reporting on this item, Transfer or Discharge not to an inpatient facility and "look back" to the date of the most recent of SOC/ROC.
 - Select response 0 or 1 when any portion of the quality episode occurs between October 1 and March 31.
 - Select NA when none of the quality episode dates occur between October 1 and March 31.
- 3. Record information on medication record and/or designate a specific area of the medical record when agency staff does administer the flu vaccine.
- 4. Responses to M1040 and M1045 are combined to report the percentage of eligible patients who received influenza immunization for the current flu season.

M1040/1045 Process Implications: Influenza immunization received for current flu season Clinical Recommendations

- Offer flu immunization when appropriate.
- All care providers need to be responsible for documenting flu immunization information when they
 find out about it during the episode.
- Document administration of flu shot on medication chart, in the clinical note and in a tracking system.
- Educate staff on age/condition guidelines from the CDC regarding flu immunizations.

- Consider administering these vaccines if you currently do not. Understand sensitive of vaccines to temperature, especially during transportation.
- Develop/review policy related to this immunization compliant with CDC recommendation including storing and transporting vaccine.
- Create/review practice for retrieving immunization information from referring facilities. Collecting immunization information from referral source could be another marketing opportunity.
- Designate tracking system and/or designated area of record for documenting and storing immunization information. Identify how information will be available to clinician at the time of transfer or discharge.

M104	Reason Influenza Vaccine not received: If the patient did not receive the influenza vaccine from your agency during this episode of care, state reason:
	 □ 1 - Received from another health care provider (e.g., physician) □ 2 - Received from your agency previously during this year's flu season □ 3 - Offered and declined □ 4 - Assessed and determined to have medical contraindication(s) □ 5 - Not indicated; patient does not meet age/condition guidelines for influenza vaccine □ 6 - Inability to obtain vaccine due to declared shortage □ 7 - None of the above
Item	Intent
home the C vacci	ifies the reason that a patient did not receive an influenza vaccine from your agency during this health care episode of care (from SOC/ROC to transfer or discharge). For each influenza season, tenters for Disease Control (CDC) recommend the timeframes for administration of the influenza nes. Responses to M1040 and M1045 are combined to report the percentage of eligible patients received influenza immunization for the current flu season.
Time	Points Item(s)
TRF	DC
Optima	al Question
•	Have you had a seasonal flu shot this year? Who gave it to you and when? Why have you not received it?
Optima	al Strategy/Technique
•	Maintain a record of flu and pneumonia immunizations beginning at SOC. Keep it in a consistent spot of the medical record. Read clinical notes if necessary. Retrieve the information at this time point.
Tips	
1.	Use the tracking system or designated area of the record where flu immunizations are recorded to score this item at this Transfer or Discharge not to inpatient facility time point.
2.	Select response which identifies if the patient has received the flu vaccine for this season and why your agency may not have administered it during this quality episode.

- 3. If an agency has elected not to administer vaccines to their patients, and the reasons listed in responses 1 through 6 do not apply, then response 7 None of the above, would be the appropriate response.
- 4. Encourage eligible patients to be current with flu vaccines.
- 5. Know the age/condition guidelines for the seasonal flu vaccine from the CDC and whether patient qualifies to receive.

http://www.cdc.gov/vaccines/default.htm

http://www.cdc.gov/flu/

http://www.cdc.gov/az/

6. Responses to M1040 and M1045 are combined to report the percentage of eligible patients who received the seasonal flu immunization.

M1040/1045 Process Implications: Influenza immunization received for current flu season Clinical Recommendations

Offer flu immunization when appropriate.

- All care providers need to be responsible for documenting flu immunization information when they find out about it during the episode.
- Document administration of flu shot on medication chart, in the clinical note and in a tracking system.
- Educate staff on age/condition guidelines from the CDC Re: flu immunizations.

- Consider administering these vaccines if you currently do not. Understand sensitivity of vaccines to temperature, especially during transportation.
- Develop/review policy related to this immunization compliant with CDC recommendation including storing and transporting vaccine.
- Create/review practice for retrieving immunization information from referring facilities. Collecting immunization information from referral source could be another marketing opportunity.
- Designate tracking system and/or designated area of record for documenting and storing immunization information. Identify how information will be available to clinician at the time of transfer or discharge.

M1050 Pneumococcal Vaccine: Did the patient receive pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge)? □ 0 − No

☐ 1 – Yes [Go to M1500 at TRN; Go to M1230 at DC]



Item Intent

Identifies whether the patient received a PPV from the home health agency during this episode of care (from SOC/ROC to transfer or discharge). This item does not assess PPVs given by another care provider or provision of the PPV by your agency prior to the most recent SOC/ROC, as that information will be reported in M1055. Responses to M1050 and M1055 are combined to report the percentage of eligible patients who ever received PPV.

Time Points Item(s)

TRF DC

Optimal Question

 Have you ever had a pneumonia vaccine? Who gave it to you and when? Why have you not received it?

Optimal Strategy/Technique

- Determine dates of quality episode. Identify whether agency staff administered the pneumonia vaccine on a date within the quality episode.
- Document when and who administered the pneumonia vaccine in an agency specified and consistent location of the medical record throughout the episode(s) of care.

Tips

- 1. Maintain a record of flu and pneumonia vaccines, including date and which health provider administered, so that it is available for easy retrieval at this time point.
- 2. Determine the quality episode for reporting on this item, Transfer or Discharge not to an inpatient facility and "look back" to the date of the most recent of SOC/ROC.
- 3. Record information on medication record and/or designate a specific area of the medical record when agency staff does administer the pneumonia vaccine.
- Responses to M1050 and M1055 are combined to report the percentage of eligible patients who ever received PPV.

M1050/1055 Process Implications: Pneumonia immunization ever received Clinical Recommendations

- Offer pneumonia immunizations when appropriate.
- All care providers need to be responsible for documenting pneumonia immunization information when they find out about it during the episode.
- Document administration of PPV on medication chart, in the clinical note and in a tracking system.
- Educate staff re: CDC age/condition recommendations for PPV.

- Consider administering these vaccines if you currently do not. Collecting immunization info from referral source could be another marketing opportunity.
- Maintaining adult immunization records for flu and pneumonia vaccines.
- Develop/ review policy related to this vaccine compliant with CDC recommendations including storing and transporting vaccine.
- Create/review practice for retrieving immunization information from referring facilities.
- Designate tracking system and/or designated area of record for documenting and storing immunization information. Determine how information will be available to clinician at the time of transfer or discharge.

M105	Reason PPV not received: If patient did not receive the pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge), state reason: 1 - Patient has received PPV in the past 2 - Offered and declined 3 - Assessed and determined to have medical contraindication(s) 4 - Not indicated; patient does not meet age/condition guidelines for PPV 5 - None of the above
ltem	Intent
(from	ains why the patient did not receive a PPV from the home health agency during this episode of care SOC/ROC to transfer or discharge). Responses to M1050 and M1055 are combined to report the entage of eligible patients who ever received PPV.
Time	Points Item(s)
TRF	DC
Optima	al Question
•	Have you ever received the pneumonia vaccine? Who gave it to you? When?
Optima	al Strategy/Technique
•	Maintain a record of flu and pneumonia immunizations beginning at SOC. Keep it in a consistent spot of the medical record. Read clinical notes if necessary. Retrieve the information at this time point.
•	Ask question at time of referral. Ask physician.
Tips	
1.	Use the tracking system or designated area of the record where PPV immunizations are recorded to score this item at this Transfer or Discharge not to inpatient facility time point.
	 Select 0 No if agency personnel did not administer PPV during this quality episode
	 Select 1 Yes if agency personnel did administer PPV during this quality episode
2.	Select response which identifies if the patient has ever received a PPV (It does not include whether booster recommendations have been followed.) and why your agency may not have administered it during this quality episode
3.	If an agency has elected not to administer PPV to their patients, and the reasons listed in responses 1 through 4 do not apply, then response 5 - None of the above, would be the appropriate response.
4.	Encourage eligible patients to be current with PPV.
5.	Know the age/condition guidelines for the pneumonia vaccine from the CDC and whether patient qualifies to receive. http://www.cdc.gov/vaccines/default.htm http://www.cdc.gov/vaccines/vpd-vac/pneumo/default.htm http://www.cdc.gov/vaccines/vpd-vac/pneumo/default.htm
6.	Responses to M1050 and M1055 are combined to report the percentage of eligible patients who ever received PPV.
CON	ITINUED

M1050/1055 Process Implications: Pneumonia immunization ever received

Clinical Recommendations

- Offer pneumonia immunizations when appropriate.
- All care providers need to be responsible for documenting pneumonia immunization information when they find out about it during the episode.
- Document administration of PPV on medication chart, in the clinical note and in a tracking system.
- Educate staff re: CDC age/condition recommendations for PPV.

- Consider administering these vaccines if you currently do not. Collecting immunization info from referral source could be another marketing opportunity.
- Maintaining adult immunization records for flu and pneumonia vaccines.
- Develop/ review policy related to this vaccine compliant with CDC recommendations including storing and transporting vaccine.
- Create/review practice for retrieving immunization information from referring facilities.
- Designate tracking system and/or designated area of record for documenting and storing immunization information. Determine how information will be available to clinician at the time of transfer or discharge.

M1100 Patient Living Situation: Which of the following best describes the patient's residential circumstance and availability of assistance? (Check one box only.)

M1100

	Availability of Assistance				
Living Arrangement	Around the clock	Regular daytime	Regular nighttime	Occasional / short-term assistance	No assistance available
a. Patient lives alone	□ 01	□ 02	□ 03	□ 04	□ 05
b. Patient lives with other person(s) in the home	□ 06	□ 07	□ 08	□ 09	□ 10
c. Patient lives in congregate situation (e.g., assisted living)	□ 11	□ 12	□ 13	□ 14	□ 15

Item Intent

This item identifies, using the care provider's professional judgment, a) whether the patient is living alone or with other(s) and b) the availability of caregiver(s) (other than home health agency staff) to provide inperson assistance.

Time Points Item(s)

SOC ROC

Optimal Question

Are you living here temporarily or permanently? Who usually lives with you? Who is usually able
to help you with things like dressing, bathing, meals, laundry, etc.? How often are they here (in
person) to help you?

Optimal Strategy/Technique

- Confirm patient reports with caregivers when possible.
- If patient is in assisted living, check with director as to what assistance is being provided for this
 patient by contract.

- 1. Select usual living situation first (row a, b, or c). Then determine the amount of time someone is in person in the home to meet the patient's needs e.g., any task necessary to stay safely in the home environment.
- 2. Select the response that best reflects usual situation. This is different from OASIS B.
- 3. Assistance refers to "in person" only.
- 4. A person in an assisted living or congregate setting with a call-bell that summons help, is considered to have in-person assistance.

M1200 Vision (with corrective lenses if the patient usually wears them): O - Normal vision: sees adequately in most situations; can see medication labels, newsprint. O - Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length. O - Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive. Item Intent Identifies the patient's ability to see and visually manage (function) safely within his/her environment, wearing corrective lenses if these are usually worn. Time Points Item(s) SOC ROC FU

Optimal Question

 Do you wear glasses or use reading glasses? Can the patient function safely in his environment with the vision he has?

Optimal Strategy/Technique

- Ask patient to read medication label words or numbers or pick up a small object in front of them.
 Observe if prescriptive glasses or reading glasses are routinely used to accomplish task.
- Ambulate patient and observe if the patient can see or bumps into furniture and feels their way.
- When cognition is impaired, interview caregiver and observe patient movement/response during assessment visit to determine if there is an ability to see.

- Assess the effect the patient's vision has on safely performing ADL/IADL activity and navigating
 his environment wearing corrective lenses if he usually wears them. The focus is not on literacy
 or ability to read.
- 2. Do not limit assessment to just the patient's ability to see medication labels and small print. Does a lack of uncorrected vision jeopardize safety, health and well being? Is he/she able to see objects in path, read gauges/measures on medical equipment, see telephone numbers, see changes in walking surfaces?
- 3. Determine if a patient's impaired ability to respond to or function in his environment is due to an impairment of sight not compensated for by routine use of prescription or reading glasses or other physical impairment that limits ability to use vision (e.g. neck injury that limits ability to rotate head and neck to see objects in path or orbital swelling which limits ability to see, etc.).
- 4. Corrective lenses include:
 - a. Prescription glasses
 - b. Reading glasses, including those purchased in the grocery store
- 5. Low vision may be a functional limitation and should be considered when developing and implementing the POC/485.
- 6. Use professional judgment and determine if partially or severely impaired when:
 - a. Magnifying glass is used to see small print or medication labels
 - b. Does not regularly use glasses and he has them
 - c. Needs a different prescription for improved acuity
 - d. Limited field of vision creates safety risk with mobility, etc.
- 7. Severely impaired if:
 - a. There is lack of sight (blindness)
 - b. Is nonresponsive (unable to voluntarily respond)

M121	210 Ability to hear (with hearing aid or hearing appliance if normally used):			
	0 - Adequate: hears normal conversation without difficulty.			
	 1 - Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly. 			
	2 - Severely Impaired: absence of useful hearing.			
	☐ UK - Unable to assess hearing.			
ltem	Intent			
Ident	fies the patient's ability to hear spoken language and other sounds (e.g., alarms).			
Time	Points Item(s)			
SOC	ROC			
Optima	al Question			
•	How well does this patient hear the spoken word and other sounds?			
Optima	al Strategy/Technique			
•	Select response at the end of visit after observing patient respond to assessment.			
•	With back to patient, in a normal tone, say "5-4-3-2-1." Face patient and ask him to repeat.			
	OR			
•	With back to patient, ask at least one question. Ask patient to repeat and respond to question.			
•	Notice if patient routinely wears hearing aids.			
Tips				
1.	Using a normal tone of voice, evaluate hearing with hearing aids in place and turned on only if patient usually wears them. Note how loud the television is.			

- 2. Determine if patient speaks same language as clinician. Enlist assistance of interpreter to assess if needed.
- 3. Select the "UK" if the patient is not able to respond or if it is otherwise impossible to assess hearing (e.g., severe dementia, unconscious).

M1220	Understanding of Verbal Content in patient's own language (with hearing aid or device if used):
	☐ 0 - Understands: clear comprehension without cues or repetitions.
	 1 - Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand.
	 2 - Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.
	3 - Rarely/Never Understands
	☐ UK - Unable to assess understanding.
	the patient's functional ability to comprehend spoken words and instructions in the patient's primary b. Both hearing and cognitive abilities may impact a patient's ability to understand verbal content.
Time Po	pints Item(s)
SOC F	ROC
Optimal 0	Question
	ow well does the patient understand and/or follow commands (when spoken in native language and dialect), with hearing aid if required?
Optimal S	Strategy/Technique
	bserve how the patient responds to instructions and comprehends the spoken word (in their own alect). Use assistance of interpreter if necessary. Observe response to an open ended

Tips

question.

- 1. Interview family to ascertain whether understanding varies from time to time.
- 2. Notice how often the patient must be prompted or cued during the assessment process. Determine if it is related to a hearing impairment or cognition.
- 3. A lip reader may be able to understand spoken language.
- 4. Select "UK" if the patient is not able to respond or if it is otherwise impossible to assess understanding of spoken words and instructions.

M1230 Speech and Oral (Verbal) Expression of Language (in patient's own language): 0 - Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment. 1 - Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance). 2 - Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences. ☐ 3 - Has severe difficulty expressing basic ideas or needs and requires maximal assistance or quessing by listener. Speech limited to single words or short phrases. 4 - Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (e.g., speech is nonsensical or unintelligible). 5 - Patient nonresponsive or unable to speak. Item Intent Identifies the patient's physical and cognitive ability to communicate with words in the patient's primary language. The item does not address communicating in sign language, in writing, or by any nonverbal means. Time Points Item(s)

Optimal Question

ROC

DC

SOC

• How well do I understand the patient's speech and what he is trying to communicate (assuming we speak the same primary language)?

Optimal Strategy/Technique

 Observe patient's ability to speak and effectively express self and communicate during assessment visit (provide answers, ideas, needs, etc.).

- 1. Focus on talking and **verbal** communication and ability to form words and produce sounds normally or by esophageal speech or use of electrolarynx.
- 2. Notice choice of words, complexity of sentences or paucity of words used.
- Determine if patient speaks same language as clinician. Enlist assistance of interpreter and document the use.
- Select response 5 when there is:
 - Inability to speak and communication is by sign language
 - Inability to respond (i.e., vegetative state, etc.)

M1240 Has this patient had a formal Pain Assessment using a standardized pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)? ☐ 0 - No standardized assessment conducted ☐ 1 - Yes, and it does not indicate severe pain

2 - Yes, and it indicates severe pain

M1240

Item Intent

Identifies if a standardized pain assessment is conducted and whether a clinically significant level of pain is present, as determined by the assessment tool used. This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.

Time Points Item(s)

SOC ROC

Optimal Question

• Did my best practice include a formal pain assessment using a standardized pain assessment tool? If yes, did it indicate the presence of severe pain?

Optimal Strategy/Technique

- Observe the patient for the effects of pain while conducting Fazzi's OASIS Walk®, the assessment strategy in which the clinician observes the patient interacting with his environment while performing/simulating functional tasks.
- Conduct a formal pain assessment using agency approved standardized tools and use the scoring parameters to determine the presence of severe pain.

Tips

- Conduct the formal pain assessment according to agency policy and within the assessment time frame, e.g. within 5 days of the SOC and 2 days of return home or knowledge of it, etc. Refer to OASIS Reference Sheet Version July 19, 2006, https://www.qtso.com/download/hha/OASIS_Ref_Sheet.07.19.06.pdf
- 2. The agency approved standardized tool must be one that has been scientifically tested and validated as effective in identifying a specified condition or risk in population with characteristics similar to the patient being evaluated. A standardized tool includes a response scale and must be appropriately administered based on established instructions.
- 3. Know the agency's critical value (definition) for severe pain.
- 4. Assessing for pain using a standardized tool is considered a best practice. Consider patient situation carefully before responding "no" to this item.
- 5. If pain present, use open ended and probing questions to determine the characteristics and current management of pain such as:
 - "What medications or actions do you take when you when you have pain?"
 - "What level of pain is acceptable to you?"
 - "When was when the last time you took pain medication?"
- 6. Use the results of the assessment to assist with care planning. Collaborate with the physician within the assessment time frame to plan interventions for monitoring and mitigating pain and place them on the POC/485.
- 7. Consider referral to rehab services and use of modalities to mitigate pain.
- 8. Place the results of the assessment in the agency designated standardized place in the record for easy reference at the Transfer and Discharge not to inpatient facility assessment time points.

Process Implications: Pain assessment conducted

Clinical Recommendations

- Conduct formal pain assessments at intervals defined by agency policy. Use results of formal
 pain assessment and observation of the patient while performing the OASIS Walk ® to develop a
 plan to manage pain.
- Select and use a pain assessment tool based on the patient's ability to respond to particular tool.
 Know the scoring mechanism of the tool define severe pain by scale scoring.
- Follow agency's standards/protocols when conducting pain assessments, identifying severe pain and developing appropriate plan of action/interventions in collaboration with the physician.
- Document findings and plan for management of pain in a consistent location of the record for easy retrieval at the transfer and discharge Time Points.

- Update/create policies and procedures to indicate care processes for identifying, monitoring and managing pain.
- Develop a template with potential options for interventions to monitor and mitigate pain (e.g. rehab services, medication, alternate forms of therapy like distraction, etc). contingent upon physician approval.
- Designate a consistent place in record to place information so it can be easily accessed at the transfer to Inpatient Facility and Discharge Time Points.
- Designate which standardized tools will be used to conduct a formal pain assessment. Train clinicians to administer correctly and define scoring parameters.
- Ensure collaboration with the physician in care planning.
- Assign responsibility for concurrent and/or retrospective record review for evidence of compliance with best practice.

M1242 Frequency of Pain Interfering with patient's activity or movement: | 0 - Patient has no pain | 1 - Patient has pain that does not interfere with activity or movement | 2 - Less often than daily | 3 - Daily, but not constantly | 4 - All of the time | Item Intent | Identifies frequency with which pain interferes with patient's activities, with treatments if prescribed. | Time Points Item(s)

Optimal Question

To what degree is pain impacting the way you do your ADLs/IADLs? Use words they can
understand to describe ADL/IADL. How often does pain affect your sleeping, eating, socializing or
other regular activity?

Optimal Strategy/Technique

SOC ROC FU DC

- As part of the OASIS Walk®, observe patient walking into bathroom and demonstrate/simulate some ADL.
- Assess mood, interactions with caregiver and for limitations of movement or restricted ability to perform activities secondary to pain during assessment process.

- 1. Consider the assessment of pain as the 5th vital sign.
- 2. In spite of pain medication and other relief measures, acute or chronic pain can interfere with activity or movement. Determine if and how often it does.
- 3. Interfering pain will cause a person to restrict an activity to be or remain pain free.
- 4. A patient may not be able to afford or choose not to use pain relief measures and the pain may interfere with movement and activity. Determine if and how often pain does interfere.
- 5. Pain that interferes will:
 - Cause activity to take longer to complete or movement to slow, be modified or postponed, or
 - · Require additional assistance of another person or device, or
 - Result in activity being performed less often than desired by the patient.
- 6. It may cause the patient to stop and seek relief (take a pain pill, etc.) before performing actions. It may be the reason for a depressed mood, low motivation, anger, anxiety, sadness, isolation or staying in the same position for extended periods of time.
- 7. If patient is nonverbal, evaluate facial expressions or physiologic responses to pain during activity or movement.
- 8. Use assessment findings to develop appropriate POC specific to the patient's needs. Focus patient outcome on reducing and improving the amount of time pain interferes with function and not just lowering the assessed level of pain.
- 9. Consider referrals to therapy services to address impact on functional activity.
- 10. Depending on the type and kind of pain, consult agency coders for appropriate use of pain diagnosis codes. Determine if pain is a functional limitation and add to Locator #14 on the POC/485 when appropriate.

M1300 Pressure Ulcer Assessment: Was this patient assessed for Risk of **Developing Pressure Ulcers?** 0 - No assessment conducted [Go to M1306] 1 - Yes, based on an evaluation of clinical factors, e.g., mobility, incontinence, nutrition, etc., without use of standardized tool 2 - Yes, using a standardized tool, e.g., Braden, Norton, other Item Intent Identifies whether the home health agency care providers assessed the patient's risk of developing pressure ulcers. CMS does not require the use of standardized tools, nor does it endorse one particular tool. This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation. Time Points Item(s) SOC ROC **Optimal Question** Did I conduct an assessment for risk of developing pressure ulcers by evaluating select clinical factors or using a standardized and validated tool? Optimal Strategy/Technique Inspect the patient's skin and conduct a pressure ulcer risk assessment following agency policy/practice. Tips 1. Assessing for the risk of developing pressure ulcers can be done by evaluating a select group of clinical factors or by using a standardized and validated tool. 2. Know agency policy/practice for conducting a pressure ulcer risk assessment. Method of assessment and use of a standardized tool is optional for CMS purposes but is directed by agency policy. 3. The agency approved standardized tool must be one that has been scientifically tested and validated as effective in identifying a specified condition or risk in population with characteristics similar to the patient being evaluated. A standardized tool includes a response scale and must be appropriately administered based on established instructions. 4. Conduct the pressure ulcer risk assessment according to agency policy and within the assessment time frame, e.g. within 5 days of the SOC and 2 days of return home or knowledge of

Note: See M1302 Process Implications

5. Assessing for the risk of developing pressure ulcers is considered a best practice. Consider

it, etc. Refer to OASIS Reference Sheet Version July 19, 2006, https://www.qtso.com/download/hha/OASIS_Ref_Sheet.07.19.06.pdf

patient situation carefully before responding "no" to this item.

M1302 Does this patient have a Risk of Developing Pressure Ulcers? □ 0 - No □ 1 - Yes

Item Intent

Identifies if the patient is at risk for developing pressure ulcers. This item should be skipped if response 0 was selected for M1300 (no pressure ulcer risk assessment).

Time Points Item(s)

SOC ROC

Optimal Question

 Based upon the assessment conducted for M1300, is this patient at risk of developing pressure ulcers?

Optimal Strategy/Technique

 Use the scoring system of the validated and standardized tool and/or the evaluation of clinical factors as defined by agency policy to determine risk. Evaluate implications when "software logic" generates a warning to alert of risk.

Tips

- Know agency policy for assessment of risk of developing pressure ulcers and the scoring parameters specified by the standardized tool and the agency defined parameters when evaluating clinical factors to identify levels of risk.
- 2. Use results of assessment and good professional judgment to plan care interventions in order to reduce risk. Confirm plan with physician.
- 3. Place results of assessment in agency designated standardized location of medical record for easy reference at the Transfer to inpatient facility or discharge not to inpatient facility assessment time points.
- 4. Examples of standardized and validated tools are:
 - Braden scale http://www.bradenscale.com/
 - Norton scale http://www.woundcarehelpline.com/NortonScale.pdf

M1300/1302 Process Implications: Pressure ulcer assessment conducted; pressure ulcer risk determined

Clinical Recommendations

- Conduct complete skin inspections at regular intervals, at a minimum at the time of all comprehensive assessments, according to agency policy and patient circumstances.
- Conduct pressure ulcer risk assessments following agency policy. Involve all disciplines.
- Know the scoring parameters of the tool or method used to assess for risk. Collaborate with the
 physician and develop an appropriate plan of action to reduce risk of pressure ulcer development
 based on discreet areas of risk. Involve all disciplines and services as needed.
- Document findings and plan for managing pressure ulcer risk in a consistent location of the record for implementation and easy retrieval at the transfer and discharge not to inpatient facility assessment time points.

- Designate which tool(s) and/or method will be used to evaluate for the risk of developing pressure
 ulcers
- Develop/monitor policy/practice related to pressure ulcer risk assessments to include how often it will occur, who will do and how to determine assessment competency. Involve all disciplines.
- Develop/monitor policy/practice related to conducting complete skin inspections for all disciplines responsible to perform a comprehensive assessment. Provide guidelines when limited skin inspections are appropriate.
- Provide training related to conducting a skin assessment and use of pressure ulcer risk assessment tool.
- Develop a template with potential interventions for each of the discreet areas of risk (eg, nutrition, moisture, mobility, activity, friction and shear, etc.).
- Ensure collaboration with the physician in planning care.
- Identify a designated location in medical record to store results of the assessment and plan for reducing risk for use implementation and reference later in the episode.
- Assign responsibility for concurrent and/or retrospective record review for evidence of compliance with this best practice.

Optimal Question

None

Optimal Strategy/Technique

- Conduct skin assessment observing pressure points closely and identify the presence of pressure ulcer(s).
- Consult agency wound care expert as needed to assist in identification of pressure ulcer stages and confirm with physician.

Tips

1. This item **includes**:

- Open and closed/ "previously healed" Stage III and IV pressure ulcers
- Open stage II pressure ulcers
- Intact or open/ruptured serum filled blister due to pressure or in combination with friction and shear
- Unstageable pressure ulcers:
 - 1. Known or suspected pressure ulcer but not able to visualize due to a dressing or device that cannot be removed due to a physician's order.
 - 2. Known or suspected pressure ulcer but unable to visualize true depth of wound due to avascular tissue (slough or eschar).
 - 3. Presence of suspected deep tissue injury in evolution.

2. This item excludes:

- Stage I pressure ulcers
- Completely epithelialized Stage II pressure ulcers
- 3. Refer to National Pressure Ulcer Advisory Panel (NPUAP) guidance at www.npuap.org and Wound Ostomy Continence Nurses Society Guidance on OASIS-C Integumentary Items at http://www.wocn.org.

M1307 The Oldest Non-epithelialized Stage II Pressure Ulcer that is present at discharge

		2	~ =
M	1	3(U/

1 -	Was present at the most recent SOC/ROC assessment
2 -	Developed since the most recent SOC/ROC assessment:
	record date pressure ulcer first identified: / / /
	m onth day year
NA	- No non-epithelialized Stage II pressure ulcers are present at discharge

Item Intent

The intent of this item is to a) identify the oldest Stage II pressure ulcer that is present at the time of discharge and is <u>not fully epithelialized</u>, and b) assess the length of time this ulcer remained unhealed while the patient received care from the home health agency and c) identify patients who develop Stage II pressure ulcers while under the care of the agency.

Time Points Item(s)

DC

Optimal Question

None

Optimal Strategy/Technique

 Conduct a skin assessment observing pressure points closely and identify the presence of a Stage II pressure ulcer(s) that is not yet healed. If ulcer present, read tracking sheet or available clinical notes to determine the date the ulcer was first noted and compare it to the most recent of SOC or ROC date.

- 1. An intact or open/ruptured serum filled blister resulting from pressure or in combination with friction and shear is a Stage II pressure ulcer.
- 2. Non-epithelialized means not healed, epithelial tissue has not yet completely covered the wound.
- 3. Determine if SOC or ROC is the most recent assessment. This identifies the starting point of the quality episode and the beginning of the reporting period under consideration for this data item.
- 4. Use of an electronic or paper tracking tool or a wound flow sheet during the episode(s) of care will assist in having this information available efficiently at the discharge not to inpatient facility assessment time points.
- 5. Refer to National Pressure Ulcer Advisory Panel (NPUAP) guidance at www.npuap.org and Wound Ostomy Continence Nurses Society Guidance on OASIS-C Integumentary Items at www.wocn.org.

M1308 Current Number of Unhealed (non epithelialized) Pressure Ulcers at Each Stage: (Enter "0" if none; excludes Stage I pressure ulcers)

M1308

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
Stage description – unhealed pressure ulcers	Number Currently Present	Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)
a. Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.		
b. Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.		
c. Stage IV: Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.		
d.1 Unstageable: Known or likely but unstageable due to non-removable dressing or device		
d.2 Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.		
d.3 Unstageable: Suspected deep tissue injury in evolution.		

Item Intent

Identifies the number of Stage II or higher pressure ulcers at each stage present at the time of assessment. Stage I pressure ulcers are <u>not</u> reported in this item.

Time Points Item(s)

SOC ROC FU DC

Optimal Question

None

Optimal Strategy/Technique

- Conduct a skin assessment observing pressure points closely and identify the presence of any
 pressure ulcer(s) that is not yet healed and for closed Stage 3 and 4 pressure ulcer(s).
- Consult agency wound care expert as needed to assist in identification of pressure ulcer and/or stage and confirm with physician.

Tips

- 1. Non-epithelialized means not healed, epithelial tissue has not yet completely covered the wound.
- 2. Stage 2 pressure ulcers that completely epithelialize are considered healed and are **not** referenced in either Columns 1 or 2.
- 3. An intact or open/ruptured serum filled blister resulting from pressure is a Stage 2 pressure ulcer.

- Closed Stage 3 and 4 pressure ulcers regardless of how long they have been completely epithelialized:
 - a) Continue to be regarded as a pressure ulcer at its worst stage
 - Are observed and counted in both columns 1 and 2
 - c) If they break down again should be staged at their worst stage.
- 5. Complete Column 1 at SOC, ROC, Follow-up (Recertification or SCIC) and Discharge-not to an inpatient facility time points.
 - a) Column 1 represents the current number of pressure ulcers at each stage and/or the number that are unstageable and observed during the skin inspection.
- 6. Complete Column 2 at the Follow Up (Recertification or SCIC) and Discharge-not to inpatient facility time points.
- 7. Determine if SOC or ROC is the most recent assessment. This identifies the starting point of the quality episode and the beginning of the reporting period under consideration for completing Column 2.
- 8. Column 2 represents the number of pressure ulcers observed during the skin inspection for Column 1 that were **present** when the skin was inspected at the most recent of SOC or ROC **even though the stage may have changed**.
- 9. Column 2 will track how many of the ulcers that were present at SOC/ROC have healed and how many new ones have appeared since SOC/ROC. Document and report observations **very carefully**.
- Document complete wound description(s) in the clinical record; location, size, depth, drainage, appearance of wound bed and surrounding skin using terms found in the WOCN and NPUAP documents.
- 11. Pressure ulcer:
 - a) Localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure or pressure in combination with shear and/or friction.
 - b) Remains when treated with a skin graft.
 - c) Remains when surgically debrided.
 - d) Occurs on foot of a person with diabetes when the root cause is pressure.
- 12. This item excludes:
 - a) Pressure ulcer closed with a muscle flap.
 - b) Current or previous Stage I pressure ulcers.
 - c) Completely epithelialized/healed Stage II pressure ulcers.
- 13. Staging:
 - a) Report an open pressure ulcer by its worst stage while it is open.
 - b) Do not reverse stage.
 - c) A Stage III or IV pressure ulcer, once closed, will continue to be reported at its worst stage regardless of the length of time that has elapsed since closure.
 - d) A previously closed stage III or IV that reopens is reported at its worst stage.
 - e) Can be determined if some eschar or slough present in wound bed as long as the deepest viable tissue is visible and the slough does not obscure the depth of the tissue loss.
- 14. A pressure ulcer closed with a muscle flap, skin advancement flap or rotational flap is a surgical wound and not considered in this item. If pressure causes the flap to break down before it completely heals, the wound is considered a non healing surgical wound and not a pressure ulcer.
- 15. If a muscle flap, skin advancement flap or rotational flap completely heals and then breaks down and the area reopens due to pressure, it is considered a new pressure ulcer.
- 16. Utilize some kind of tracking system to label and follow pressure ulcers and their progression through out the episodes of care.
- 17. Refer to National Pressure Ulcer Advisory Panel (NPUAP) guidance at http://www.npuap.org and Wound Ostomy Continence Nurses Society Guidance on OASIS-C Integumentary Items at http://www.wocn.org.

M1310/M1312/M1314: If the patient has one or more unhealed (non-epithelialized)
Stage III or IV pressure ulcers, identify the Stage III or IV pressure ulcer with the largest surface dimension (length x width) and record in centimeters. If no Stage III or Stage IV pressure ulcers, go to M1320.

, 	M13	310/
	13:	12/
	13	14

(M1310) Pressure Ulcer Length: Longest length "head-to-toe" . (cm)				
(M1312) Pressure Ulcer Width: Width of the same pressure ulcer; greatest width perpendicular to the length				
. (cm)				
(M1314) Pressure Ulcer Depth: Depth of the same pressure ulcer; from visible surface to the deepest area				
. (cm)				

Item Intent

Identifies the length, width, and depth of the pressure ulcer with the largest surface area (length x width) that is also an unhealed Stage III or IV pressure ulcer or pressure ulcer unstageable due to the presence of slough or eschar (as reported in M1308 d.2).

Time Points Item(s)

SOC ROC DC

Optimal Question

None

For M1310 and M1312: Optimal Strategy/Technique

- Conduct a skin assessment observing pressure points closely and identify the presence of Stage III and IV pressure ulcer(s) both unhealed and closed. If present, measure the length x width (surface dimension) of each. Complete these items with the measurements of the Stage III or IV pressure ulcer that has the largest surface dimension.
- Consult agency wound care expert as needed to assist in identification of pressure ulcer and stage.

Tips

- 1. Complete these items only if M1308 Column 1, rows b, c, or d.2 is greater than 0.
- 2. Measure length at the longest point of the ulcer in centimeters from head to toe.
- Measure width at the widest point of the ulcer in centimeters perpendicular to the head to toe measurement.
- 4. Also considered for this item:
 - a) Closed Stage 3 and 4 pressure ulcers, although epithelialized
 - b) Unstageable pressure ulcers from M1308 d.2 due to avascular (eschar or slough) tissue in the wound bed obscuring true wound depth
- 5. Enter "00.0" for the dimensions when the only pressure ulcers are:
 - a) Unstageable OR
 - b) A Stage 3 or 4 that is closed.

For M1314: Optimal Strategy/Technique

Measure the depth of the pressure ulcer identified in M1310 and M1312.

- 1. Measure depth in cm at deepest point with a cotton tipped applicator.
- 2. Enter 00.0 when the ulcer in M1310 and M1312 is:
 - a) Closed
 - b) Unstageable due to a device or a physician ordered non removable dressing
 - c) Filled/covered with eschar

M1320 Status of Most Problematic (Observable) Pressure Ulcer: O - Newly epithelialized 1 - Fully granulating 2 - Early/partial granulation NA - No observable pressure ulcer Item Intent Identifies the degree of closure visible in the most problematic observable pressure ulcer, stage II or higher. Please note, Stage I pressure ulcers are not considered for this item. Time Points Item(s) SOC ROC DC

Optimal Question

None

Optimal Strategy/Technique

 Use the WOCN Guidance on OASIS-C Integumentary Items revised 12/09 to select the degree of closure of the most clinically challenging Stage II or higher pressure ulcer observed during the skin inspection.

Tips

- 1. Document complete wound description in clinical record; location, size, depth, drainage, appearance of wound bed and surrounding skin using terms found in the descriptions of non healing, early partial, fully granulating and newly epithelialized wound status by the WOCN.
- 2. Use professional judgment to select the "most problematic ulcer"; it could be related to location, size, presence of infection, etc.
- 3. Exclude Stage 1 pressure ulcers.
- 4. If there is only one pressure ulcer, that is the most problematic.
- 5. If the ulcer selected is a suspected deep tissue injury in evolution, select response 3 Not healing.
- 6. When there are multiple pressure ulcers, clearly identify which ulcer is the one referenced in this item and why.
- 7. If the pressure ulcer selected is a Stage II, which includes an intact serum filled blister from pressure, its status of healing can only be response 3 Not healing; a stage II pressure ulcer does not granulate and once completely covered with epithelium is considered healed and not reported.
- 8. If the only ulcer is unobservable, consider delaying answering this item if the dressing/device will be removed and visualized by the **same** clinician within 5 days of SOC or 2 days of ROC. M0090 would then reflect the date the ulcer is visualized and the assessment is completed.
- 9. Select **N/A** when the pressure ulcer selected as the most problematic is one that cannot be seen due to presence of a dressing or device.
- 10. Refer to Wound Ostomy Continence Nurses Society Guidance on OASIS-C Integumentary Items at www.wocn.org.

Definitions:

- 1. Newly epithelialized
 - wound bed completely covered with new epithelium
 - no exudate
 - no avascular tissue (eschar and/or slough)
 - no signs or symptoms of infection

2. Fully granulating

- · wound bed filled with granulation tissue to the level of the surrounding skin
- no dead space
- no avascular tissue (eschar and/or slough)
- · no signs or symptoms of infection
- · wound edges are open

3. Early/partial granulation

- >25% of the wound bed is covered with granulation tissue
- < 25% of the wound bed is covered with avascular tissue (eschar and/or slough)
- no signs or symptoms of infection
- · wound edges open

4. Not healing

- wound with ≥25% avascular tissue (eschar and/or slough) OR
- signs/symptoms of infection OR
- clean but non-granulating wound bed OR
- closed/hyperkeratotic wound edges OR
- persistent failure to improve despite appropriate comprehensive wound management

M132	Current Number of Stage I Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue.			
	Intent fies the presence of Stage I pressure ulcers.			
	Points Item(s) ROC FU DC			
Noi				
Optimal Strategy/Technique				
•	Conduct skin assessment observing pressure points and count the number of Stage 1 pressure ulcers.			
•	Utilize agency wound care expert to assist with identifying and staging pressure ulcers and confirm with the physician.			
Tips				
1.	Do not confuse Stage 1 pressure ulcers with a deep tissue injury in evolution.			
2.	Refer to National Pressure Ulcer Advisory Panel (NPUAP) guidance at http://www.npuap.org and Wound Ostomy Continence Nurses Society Guidance on OASIS-C Integumentary Items at http://www.wocn.org .			

M13	24 Stage of Most Problematic Unhealed (Observable) Pressure Ulcer:
	☐ 1 - Stage I
	☐ 2 - Stage II
	☐ 3 - Stage III
	☐ 4 - Stage IV
	☐ NA - No observable pressure ulcer or unhealed pressure ulcer
lter	n Intent
	ntifies the stage of the most problematic observable Stage 1 or higher pressure ulcer. initions of pressure ulcer stages derived from the National Pressure Ulcer Advisory Panel.
Tim	ne Points Item(s)
SO	C ROC FU DC
Optir	mal Question
Nor	ne
Optir	nal Strategy/Technique
•	Conduct a skin assessment, use clinical judgment and select from those pressure ulcers that you can see, the one you consider to be the most problematic. Use the definitions from the National pressure Ulcer Advisory Panel (NPUAP) for staging the ulcer.
Tips	
1.	At the discretion of the clinician, the most problematic ulcer provides the greatest challenge to care and treatment for any reason.
2.	If the patient has only one pressure ulcer, that is the most problematic ulcer.
3.	If there are multiple pressure ulcers, clearly identify in documentation which ulcer is referenced in this item.
4.	Select NA if:
	There are no pressure ulcers
	 The pressure ulcer cannot be visualized due to presence of avascular tissue that obscures the true depth of the wound bed
	 The pressure ulcer cannot be visualized due to a dressing or device that cannot be removed by physician's order
5.	Document complete wound description in the clinical record; location, size, depth, drainage,

http://www.wocn.org.

appearance of wound bed and surrounding skin.

6. Refer to National Pressure Ulcer Advisory Panel (NPUAP) guidance at http://www.npuap.org and Wound Ostomy Continence Nurses Society Guidance on OASIS-C Integumentary Items at

M1330 Does this patient have a Stasis Ulcer? O - No [Go to M1340] 1 - Yes, patient has BOTH observable and unobservable stasis ulcers 2 - Yes, patient has observable stasis ulcers ONLY 3 - Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing) [Go to M1340]

Item Intent

Identifies patients with ulcers caused by inadequate venous circulation in the area affected (usually lower legs). This lesion is often associated with stasis dermatitis. Stasis ulcers DO NOT include arterial lesions or arterial ulcers. If the home health clinician conducting the assessment is not sure the wound fits the definition of a stasis ulcer, the clinician should contact the physician for clarification.

Time Points Item(s)

SOC ROC FU DC

Optimal Question

• How did you get these sores on your legs?

Optimal Strategy/Technique

- Conduct a skin inspection, especially of lower extremities for the presence of unhealed stasis ulcers.
- Consult agency wound care expert as needed to assist in identification of stasis ulcer(s) and confirm with physician.

- 1. Include:
 - Only those ulcers that are a result of poor venous circulation and
 - Have not completely epithelialized
- Exclude:
 - Arterial Ulcers
 - Previous and newly healed venous stasis ulcer (wound bed is completely covered with new epithelium)
- 3. Describe wound in clinical record; location, size, drainage, wound bed and surrounding skin, presence of pain. Support selection of this wound type with documentation of etiology and history.
- 4. **Unobservable**: cannot see due to a cast, or dressing (e.g. Unna boot, etc) that cannot be removed per physician order.
- 5. Check history, clinical information, ask patient or contact physician if there is a non-removable dressing to determine what type of ulcer is present under dressing.
- Venous Stasis Ulcer:
 - Results from disturbance in the forward flow of blood in the lower extremities
 - May occur in presence of stasis dermatitis, brown/black discoloration of the LE or non-pitting (brawny) edema
 - Usually located medial aspect of lower extremity and ankle, superior to medial malleolus and seldom, if ever, on foot or above knee
 - Appearance: irregular wound margins, color of base ruddy, granulation frequently present, shallow, superficial crater, exudate is moderate to heavy
 - Surrounding skin with edema, possible induration, cellulitis
 - Associated with minimal pain
 - "Counted" even if it has a scab, crust or necrotic tissue
 - Treated with a skin graft remains a stasis ulcer
- 7. For more information--WOCN Clinical Fact Sheets re: Quick Assessment of Leg Ulcers, http://www.wocn.org/pdfs/WOCN Library/Fact Sheets/C QUICK1.pdf
- 8. Refer to Wound Ostomy Continence Nurses Society Guidance on OASIS-C Integumentary Items at http://www.wocn.org.

M1332 Current Number of (Observable) Stasis Ulcer(s):			
	☐ 1 - One		
	☐ 2 - Two		
	3 - Three		
	☐ 4 − Four or more		
Item	Intent		
Identi	fies the number of visible (observable) stasis ulcers.		
Time	Points Item(s)		
SOC	ROC FU DC		
Optima	al Question		
Nor	ne		
Optima	al Strategy/Technique		
•	During skin inspection, count only those stasis ulcers that can be seen/visualized.		
Tips			
1.	Count only ulcers that are not under a non removable dressing or cast that have not completely epithelialized.		
2.	Exclude a stasis ulcer that has a wound bed is completely covered with new epithelium. It is considered healed and not reported for this item.		
3.	Refer to Wound Ostomy Continence Nurses Society Guidance on OASIS-C Integumentary Items		

at http://www.wocn.org.

M1334 Status of Most Problematic (Observable) Stasis Ulcer: | 0 - Newly epithelialized | 1 - Fully granulating | 2 - Early/partial granulation | 3 - Not healing | Item Intent | Identifies the degree of healing present in the most problematic, observable stasis ulcer. The "most problematic" ulcer may be the largest, the most resistant to treatment, an ulcer that is infected, etc.,

Time Points Item(s)

SOC ROC FU DC

depending on the specific situation.

Optimal Question

None

Optimal Strategy/Technique

• Use the WOCN Guidance on OASIS-C Integumentary Items revised 12/09 to select the level of healing of the most clinically challenging stasis ulcer observed during the skin inspection.

Tips

- 1. Use professional judgment to select the "most problematic" stasis ulcer; it could be related to location, size, presence of infection, etc.
- 2. Document complete wound description(s) in the clinical record; location, size, depth, drainage, appearance of wound bed and surrounding skin using terms found in the descriptions of non healing, early partial, and fully granulating wound status by the WOCN.
- 3. "Newly epithelialized" will **never** be selected for this item; once the wound bed of a stasis ulcer is completely covered with new epithelium and there are no S/S of infection, the stasis ulcer is considered healed and no longer reported for OASIS items.
- 4. If the only ulcer is unobservable, consider delaying answering this item if the dressing will be removed and visualized by the **same** clinician within 5 days of SOC or 2 days of ROC. M0090 would then reflect the date the ulcer is visualized and the assessment is completed.
- 5. If there are multiple stasis ulcers, clearly identify in documentation which ulcer is reflected in the response selection.
- 6. Refer to Wound Ostomy Continence Nurses Society Guidance on OASIS-C Integumentary Items at http://www.wocn.org.

Definitions

Newly epithelialized (Note: Although a definition for this term is provided, this level of healing is not applicable in this item.)

- wound bed completely covered with new epithelium
- no exudate
- no avascular tissue (eschar and/or slough)
- no signs or symptoms of infection

Fully granulating

- wound bed filled with granulation tissue to the level of the surrounding skin
- no dead space
- no avascular tissue (eschar and/or slough)

- no signs or symptoms of infection
- wound edges are open

Early/partial granulation

- >25% of the wound bed is covered with granulation tissue
- < 25% of the wound bed is covered with avascular tissue (eschar and/or slough)
- no signs or symptoms of infection
- wound edges open

Not healing

- wound with >25% avascular tissue (eschar and/or slough) OR
- signs/symptoms of infection OR
- clean but non-granulating wound bed OR
- closed/hyperkeratotic wound edges OR
- persistent failure to improve despite appropriate comprehensive wound management

Optimal Question

Have you had any surgery recently and/or while you were in the hospital?

Optimal Strategy/Technique

 Conduct a full body skin assessment to identify the presence of a surgical wound(s) that have not become a scar.

Tips

 If the only surgical wound is not observable due to a non removable dressing, consider delaying answering this item if dressing will be removed and visualized by the **same** clinician within the 5 day assessment time period of SOC or 2 days of ROC. M0090 would then reflect the date the ulcer is visualized and the assessment is completed.

2. Include:

- · Wounds resulting from a surgical procedure that have not become a scar
 - Observable: can be seen/visualized
 - 2. Unobservable: cannot be visualized due to a cast or dressing that cannot be removed due to a physician's order.
- Implanted venous access devices even if the implantation site has healed. Device does not need to be functional or accessed. These are central lines placed by a surgical procedure.
- Orthopedic pin sites, central line sites, stapled or sutured incisions.
- Peritoneal dialysis catheter, AV shunt.
- Wounds with drains, even after the drain is pulled until it heals and becomes a scar.
- Surgical incision with well approximated edges and a scab (i.e., crust) from dried blood or tissue fluid.
- Muscle flap, skin advancement flap or rotational flap to surgically replace a pressure ulcer.
- Gastrostomy closed by a surgical "take down" procedure.
- A shave, punch or excisional biopsy to remove and/or diagnose skin lesions.
- Abscess **treated** by incision and drainage **with** placement of a drain.
- Surgical repair of a traumatic injury.
- Arthrocentesis site when a surgical procedure is performed by arthroscopy.

3. Exclude:

- · A surgical scar
 - 1. Surgical wound that has been completely epithelialized for about 30 days or more with no S/S of infection and no evidence of complications.
- All "ostomies" except a bowel ostomy closed by a surgical "take down" procedure.
- Debridement or the placement of skin grafts.
- PICC lines (peripherally inserted).
- Gastrostomy allowed to close on its own without surgical intervention.
- Pressure ulcers treated by surgical debridement.

- Suturing of a traumatic laceration.
- Abscess **treated** by incision and drainage **without** placement of a drain.
- Cataract surgery, surgery to the mucosal membranes or a gynecological surgical procedure via a vaginal approach (wound is not of the integument).
- Aspiration of fluid by needle without placement of a drain.
- · Cardiac catheterization performed by needle puncture.
- 4. Refer to Wound Ostomy Continence Nurses Society Guidance on OASIS-C Integumentary Items at http://www.wocn.org.

M1342 Status of Most Problematic (Observable) Surgical Wound: 0 - Newly epithelialized ☐ 1 - Fully granulating 2 - Early/partial granulation 3 - Not healing Item Intent Identifies the degree of healing present in the most problematic, observable surgical wound. Time Points Item(s) SOC ROC FU DC **Optimal Question**

None

Optimal Strategy/Technique

Use the WOCN Wound Guidance document revised 12/09 to select the level of healing of the most clinically challenging surgical wound.

Tips

- Use professional judgment to select the "most problematic" surgical wound; it could be related to location, size, presence of infection, etc.
- Document complete wound description(s) in the clinical record; location, size, depth, drainage, appearance of wound bed and surrounding skin using terms found in the descriptions of non healing, early partial, fully granulating, and newly epithelialized wound status by the WOCN.
- If there are multiple surgical wounds that can be seen, clearly identify in documentation which ulcer is reflected in the response selection.
- Once a wound becomes a scar (after 30 days of complete epithelialization with no S/S of complication) it is no longer reported here unless it is an implanted venous access or infusion device.
- If the only surgical wound considered for this item is an implanted venous access or infusion device select response 0 when the implantation site has been completely epithelialized for longer than 30 days.
- Refer to Wound Ostomy Continence Nurses Society Guidance on OASIS-C Integumentary Items at http://www.wocn.org.

Definitions: (Note: This guidance applies to surgical wounds closed by either primary intention (i.e. approximated incisions) or secondary intention (i.e. open surgical wounds).

1. Newly epithelialized

- wound bed completely covered with new epithelium
- no exudate
- no avascular tissue (eschar and/or slough)
- · no signs or symptoms of infection

2. Fully granulating

- wound bed filled with granulation tissue to the level of the surrounding skin
- no dead space
- no avascular tissue (eschar and/or slough)
- no signs or symptoms of infection
- wound edges are open

CONTINUED

3. Early/partial granulation

- >25% of the wound bed is covered with granulation tissue
- < 25% of the wound bed is covered with avascular tissue (eschar and/or slough)
- no signs or symptoms of infection
- wound edges open

4. Not healing

- wound with >25% avascular tissue (eschar and/or slough) OR
- signs/symptoms of infection OR
- clean but non-granulating wound bed OR
- closed/hyperkeratotic wound edges OR
- · persistent failure to improve despite appropriate comprehensive wound management

M1350 Does this patient have a Skin Lesion or Open Wound, excluding bowel ostomy, other than those described above that is receiving intervention by the home health agency? □ 0 − No □ 1 − Yes Item Intent Identifies the presence or absence of a skin lesion or open wound NOT ALREADY ADDRESSED IN PREVIOUS ITEMS that is receiving clinical assessment or intervention from the home health agency.

Optimal Question

Time Points Item(s)
SOC ROC FU DC

• Do you have any other sores, wounds or skin changes (use words they can relate to), other than the ones we have already looked at and discussed?

Optimal Strategy/Technique

Inspect skin observing for skin lesions requiring skilled clinical intervention other than pressure
and stasis ulcers and surgical wounds. Only answer yes if the plan of care also includes a clinical
intervention related to the lesion/wound.

Tips

- 1. Skin lesion:
 - Area of pathologically altered tissue
 - · Primary lesions (arising from previously normal skin) such as vesicles, pustules, wheals
 - Secondary lesions (resulting from changes in primary lesions) such as crusts, ulcers, scar
 - Changes in color or texture such as maceration, scale, lichenification
 - Changes in shape of skin surface such as edema, cyst, nodule
 - Breaks in skin surfaces such as abrasion, excoriation, fissure, skin tears
 - Vascular lesions such as petechiae, ecchymosis
- With physician orders for clinical intervention by agency staff include skin lesions and open wounds such as:
 - Any skin condition
 - non-bowel ostomies (new with OASIS C)
 - PICC lines and IV sites
 - · arterial ulcers
 - trauma wounds
 - burns
 - abscesses
 - diabetic ulcers
 - cellulitis
 - skin tears
 - Wounds, ulcers, rashes, crusts, bruises, sores
 - Peristomal skin breakdown
 - Exit site in the abdominal wall for a peritoneal dialysis catheter

3. Excludes:

- Bowel ostomies
- Any skin lesion or open wound not receiving clinical intervention by agency staff
- Cataract surgery, surgery to the mucosa and gynecological surgical procedure by a vaginal approach
- Pressure ulcers
- · Stasis ulcers
- Surgical wounds
- Tattoos or piercings (unless receiving ongoing care by the agency)
- 4. Clinical interventions include:
 - · Observation, assessment and monitoring
 - Treatment
 - Teaching and training for wound management and care

M1400	When is the patient dyspneic or noticeably Short of Breath ? O - Patient is not short of breath 1 - When walking more than 20 feet, climbing stairs 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances	M1400		
	than 20 feet) 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation 4 - At rest (during day or night)			
Item Intent Identifies the level of exertion/activity that results in a patient's dyspnea or shortness of breath.				
	pints Item(s) ROC FU DC			

Optimal Question

- Have you been short of breath in the last 24 hrs?
- What types of activities make it hard for you to breathe?
- Do you ever have to stop/sit to catch your breath?
- Do you ever wake up having trouble breathing?
- How many pillows do you use at night?

Optimal Strategy/Technique

- Look for displays of shortness of breath throughout the assessment process (e.g. when observing ambulation, transfer, demonstration/simulation of ADL and IADL via the OASIS Walk®).
- Note level of exertion which causes any noticeable shortness of breath.
- Observe number of pillows stacked on bed.
- If chairfast, evaluate by listening to patient talk, wheel to another room, reach for items, transfers.
- Verify patient reported information with caregiver.

- Patient must perform some activity and movement in order to evaluate the level of exertion required to produce shortness of breath.
- 2. Given that focus is on impact of dyspnea on functional ability, consider referrals to therapy services (PT, OT) with focus on energy conservation strategies.
- 3. Report what is true at the time of assessment and in the 24 hr preceding.
- 4. Evaluate the bedbound or chair bound patient while performing ADL and at rest and select corresponding level of exertion which produces shortness of breath.
- 5. If oxygen usually worn continuously, assess patient response while using oxygen.
- 6. If oxygen used intermittently, do **not** assess patient response while using oxygen.
- 7. Emotional states such as anxiety and agitation, illnesses and body types can produce shortness of breath.
- 8. Select response 4 if shortness of breath occurs while supine (orthopnea).
- 9. Excludes sleep apnea unless accompanied by an episode of shortness of breath.
- 10. Use tape measure in home to measure distance of 20'.

M1410	Respiratory Treatments utilized at home: (Mark all that apply.)
	☐ 1 - Oxygen (intermittent or continuous)
	☐ 2 - Ventilator (continually or at night)
	3 - Continuous / Bi-level positive airway pressure
	4 - None of the above
ltem l	ntent
Identif	ies any of the listed respiratory treatments being used by this patient in the home.
Time	Points Item(s)
SOC	ROC DC
Optima	Question
•	Do you ever use equipment to help you with your breathing?
•	Do you ever use portable oxygen?
•	I see you have breathing equipment. Tell me how you use it?
Optima	Strategy/Technique
•	Observe environment for evidence of respiratory equipment.
•	Verify patient report with caregiver and physician.
Tips	
	Applies only to the treatments listed in the response items: (Oxygen, Ventilator, C-Pap and Bi-Pap).

2. Note: Bi-pap is a new addition to the list.

4. Be sure to mark <u>all</u> that apply.

3. If patient uses supplemental oxygen with the ventilator, mark both "1" and "2".

M1500 Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (such as dyspnea, orthopnea, edema, or weight gain) at any point since the previous OASIS assessment? ☐ 0 - No [Go to M2004 at TRN; Go to M1600 at DC] ☐ 1 - Yes 2 - Not assessed [Go to M2004 at TRN; Go to M1600 at DC] □ NA - Patient does not have diagnosis of heart failure [Go to M2004 at TRN; Go to M1600 at DC] Item Intent Identifies whether a patient with a diagnosis of heart failure experienced one or more symptoms of

heart failure at the time of the most recent OASIS assessment or since that time.

This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices/assessments stated in the item are not necessarily required in the Conditions of Participation.

Time Points Item(s)

TRF DC

Optimal Question(s)

Have you had symptoms and/or treatment for heart failure since we have been coming to see you?

Optimal Strategy/Technique

- "Look back" to the most recent OASIS assessment to establish the quality episode for reporting. Determine if a diagnosis of heart failure is present in M1010 Inpatient DX, and/or M1016 DX causing change in TX Regimen, and/or M1020/1022/1024 DX.
- Review tracking sheet established at SOC to capture the information and/or clinical documentation and identify if heart failure symptoms were present during the quality episode.

Tips

- 1. It would be highly unusual for a diagnosis of heart failure to be resolved (i.e. heart transplant) from one OASIS assessment to a subsequent assessment.
- 2. "Look back" from this transfer or discharge, not to inpatient facility assessment time point, to the most recent OASIS assessment to establish the quality episode for reporting.
- 3. "Since" means at the time of or since the previous assessment.
- 4. If the diagnosis of heart failure is present in the most recent OASIS assessment in M1010, M1016 or M1020/1022/1024:
 - Select "NO" if there is no evidence of heart failure symptoms on or since that OASIS assessment.
 - Select "YES" if there is evidence of heart failure symptoms on or since that OASIS assessment.
 - Select "NOT ASSESSED" if clinical practice/notes did not include observation for signs of heart failure on or since that OASIS assessment. (e.g. at Transfer timepoint, may be the correct answer if the patient developed symptoms and hospitalized with CHF before the clinician had an opportunity to visit patient and assess the symptoms, etc.).
 - Select "NA" if the DX of heart failure does not appear on the prior OASIS assessment.

M1500 Process Implications

Clinical Recommendations

- Standardize heart failure assessment for all disciplines that complete OASIS.
- Establish standards of care/agency practices for patients with heart failure.
- Establish processes for effective communication among all clinicians involved in care about presence of heart failure symptoms.
- Communicate management of heart failure in report when transferring care of patient from one discipline to another.
- Educate all clinicians in signs/symptoms of heart failure and discipline appropriate responses/interventions.
- Document signs/symptoms in consistent place for easy retrieval.

Operational Recommendations

- Standardize documentation of signs/symptoms for heart failure.
- Create a template for potential interventions to use in care planning if the patient has a DX of heart failure.
- Develop tools and establish documentation protocols to capture and share incidences of heart failure symptoms in real time beginning at the SOC via software program or on a tracking sheet so they are easily accessible at this transfer or discharge time point.
- Ensure assessing clinician has access to the most recent OASIS assessment.
- Assign clinical manager for tracking heart failure patients.
- Establish a practice of 100% review for all Transfer and DC assessments until competency of staff established.

M1510 Heart Failure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure since the previous OASIS assessment, what action(s) has (have) been taken to respond? (Mark all that apply.)



☐ 0 - No action taken
1 - Patient's physician (or other primary care practitioner) contacted the same day
☐ 2 - Patient advised to get emergency treatment (e.g., call 911 or go to emergency room)
☐ 3 - Implement physician-ordered patient-specific established parameters for treatment
4 - Patient education or other clinical interventions
5 - Obtained change in care plan orders (e.g., increased monitoring by agency, change in visit frequency, telehealth, etc.)

Item Intent

Identifies actions the home health care providers took in response to symptoms of heart failure that occurred at the time of the most recent OASIS assessment or since that time. This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.

Time Points Item(s)

TRF DC

Optimal Question

What actions did you take when you developed symptoms of worsening heart failure?

Optimal Strategy/Technique

- Verify identification of the most recent OASIS before responding.
- Review clinical documentation, preferably using tracking sheets, to identify all interventions employed when heart failure symptoms existed.
- "Look back" to the most recent OASIS assessment to establish the quality episode for reporting.
 Determine if a diagnosis of heart failure is present in M1010 Inpatient DX, and/or M1016 DX causing change in TX Regimen, and/or M1020/1022/1024 DX.
- Review tracking sheet established at SOC to capture the information and/or clinical documentation and identify what actions were taken during the quality episode.

Tips

- 1. Ensure that all disciplines involved in care know that the patient has heart failure.
- Refer to the tracking system initiated at SOC containing the relevant information, or read clinical notes to respond to this item at this transfer or discharge not to inpatient facility assessment time point.
- 3. Include interventions implemented by any clinician/team member during the quality episode.
- 4. Document rationale in the clinical record if there was a failure to respond to heart failure symptoms.
- "Patient specific established parameters for treatment" means that the physician has provided an order that identifies specific parameters or guidelines for implementing treatment based on the patient's condition (e.g., additional dose of diuretic if pt gains 3 pounds in 2 days).

M1510 Process Implications

Clinical Recommendations

- Develop physician approved core heart failure interventions that can be tailored to meet individual patient needs:
 - 1. Standardize heart failure assessment for all disciplines who complete OASIS.
 - 2. Adopt standard clinical guidelines for heart failure follow-up.
 - 3. Standardize patient education for heart failure.
 - 4. Mimic core measure review by hospitals for weekly review of heart failure patient to reinforce clinician behavior and responses.
 - Flag heart failure patients for after-hours triage and promote standardized responses.
 - 6. Develop algorithm for standardized response to home care heart failure patients.
 - 7. Employ patient specific parameters and PRN interventions in the plan of care as often as possible. Confirm plan with the physician.
 - 8. Recommend telehealth/telemonitoring for appropriate patients.
 - 9. Educate all clinicians in signs/symptoms of heart failure and discipline appropriate responses.

Operational Recommendations

- Create a tracking sheet/system for use beginning at the SOC to document heart failure interventions in real time.
- Assign clinical manager for oversight for heart failure patients.
- Require that each discipline discharge summary address actions taken in response to heart failure.
- Communicate information when care of patient being transferred from one discipline to another.
- Conduct 100% review of all transfer and discharge assessments until competency established.

M1600	Has this patient been treated for a Urinary Tract Infection in the past 14 days? □ 0 - No □ 1 - Yes □ NA - Patient on prophylactic treatment	M16
	☐ UK - Unknown	
Item Inte	ent s treatment of urinary tract infection during the past 14 days.	
Time Po	vints Item(s)	
SOC F	ROC DC	

Optimal Question

- Have you experienced any burning or pain upon urinating or frequency urination AND been on medicine in the past 14 days for a urinary problems?
- Have you been told that you had a bladder or kidney infection in the past 2 weeks AND been told you were to take medication for a kidney or bladder infection?

Optimal Strategy/Technique

- · Once answered, determine time frame.
- Review history and physical from all referral sources.
- Review current and past prescriptions.
- Check clinical documentation and referral information.
- Ask physician if urinary tract infection suspected but not verified.

- 1. Determine "past 14 days" by looking at a calendar. Determine the day of the week for SOC/ROC or discharge. Look back to the same day 2 weeks previous. Treatment for a UTI occurring on or during these days are "the past 14 days".
- 2. Select "YES" if:
 - a. Has symptoms/positive culture and/or treatment prescribed.
 - b. A patient is on prophylactic treatment and develops a UTI.
- 3. Select "NO" if:
 - a. Has symptoms/positive culture **and no** prescribed treatment.
 - b. Treatment ended more than 14 days ago.

M1610 Urinary Incontinence or Urinary Catheter Presence: Go to M1620] 1 - Patient is incontinent 2 - Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) [Go to M1620] Item Intent Identifies presence of urinary incontinence or condition that requires urinary catheterization of any type, including intermittent or indwelling. The etiology (cause) of incontinence is not addressed in this item.

Time Points Item(s)

SOC ROC FU DC

Optimal Question

- Do you ever have trouble holding your urine, leak urine, dribble, or not make it to the bathroom in time? Do your pants ever get damp with urine?
- Are you able to avoid leaking urine only because you are on a time schedule for emptying your bladder?

Optimal Strategy/Technique

- Observe patient's clothing and environment: check chair for stains, wet spots, pads, other protective devices, wet or sticky floors, odors.
- Look for blue pads, adult briefs, panty liners, equipment, or other protective/catheter supplies in the home.
- Interview caregiver.

- 1. Limitation of social interactions may be due to incontinence.
- 2. Review for related medication clues e.g. diuretics, detrol.
- 3. Consider medical conditions that may cause urinary frequency leading to incontinence: e.g. urinary tract infection, prostate condition, diabetes, pelvic prolapse, pelvic surgery, neurological conditions.
- 4. For a patient who was previously incontinent, use clinical judgment, current clinical guidelines, and assessment findings to determine if the cause of incontinence has been resolved and the patient is no longer incontinent.
- Urinary incontinence may result from physiologic reasons, cognitive impairments, or mobility problems. Use of a diaper by choice (e.g. at night to avoid getting out of bed) may not be incontinence.
- 6. When incontinence is driven by cognitive, mobility, or self care issues (such as management of clothing) consider referral to therapy services to address these issues.
- 7. Select response 0 if patient has anuria.

M1615	When does Urinary Incontinence occur?	M161
	0 - Timed-voiding defers incontinence	IVITO
	1 - Occasional stress incontinence	
	2 - During the night only	
	3 - During the day only	
	☐ 4 - During the day and night	
Item Inte	ent s when the urinary incontinence occurs.	
Time Po	pints Item(s)	
SOC R	ROC DC	

Optimal Question

- When (what time of day) do you have trouble holding your urine?
- Do you leak urine at night?

Optimal Strategy/Technique

- Check referral, clinical record, history for information.
- Interview of patient and caregivers.

- 1. Note: addition of "timed-voiding defers incontinence" and "occasional stress incontinence" are new to OASIS-C.
- 2. Clinical judgment is required to determine if the last urinary accident is in the **relevant past** or if the patient's current use of timed-voiding is 100% effective.
- 3. Timed voiding defers includes:
 - a. Actively practicing a timed voiding program which results in no episodes of incontinence in the relevant past
 - b. "Relevant past" is a discretionary decision of the assessing clinician based on evaluation of the patient's circumstances
- 4. Timed voiding defers excludes:
 - a. Episodes of incontinence in spite of timed voiding (use of diapers at night, etc.)
 - b. Timed voiding programs initiated with this visit
- 5. If patient experiences urinary incontinence on a regular basis, meaning almost every day, then "2", "3", or "4" would be reported.
- 6. If patient only experiences occasional stress incontinence, the correct response is 1.

M1620 Bowel Incontinence Frequency: O - Very rarely or never has bowel incontinence 1 - Less than once weekly 2 - One to three times weekly 3 - Four to six times weekly 4 - On a daily basis 5 - More often than once daily NA - Patient has ostomy for bowel elimination UK - Unknown Item Intent Identifies how often the patient experiences bowel incontinence. Refers to the frequency of a symptom

treatment of incontinence or constipation (e.g., a bowel program). Time Points Item(s)

SOC ROC FU DC

Optimal Question(s)

 How often do you leak stool? (Use bowel terms that are appropriate to the patient's culture and literacy)

(bowel incontinence), not to the etiology (cause) of that symptom. This item does not address

Do you have an ostomy for bowel elimination?

Optimal Strategy/Technique

- Observe surroundings and note stool odors.
- Observe condition of undergarments when assessing skin condition.
- Observe for bowel ostomy, rectal area skin excoriation, and determine if it is from incontinence.
- Confirm patient reports with caregiver.

aqiT

- 1. Includes:
 - the number of episodes of incontinence in spite of bowel regimen.
 - any reason the patient may not have control of his bowels.
- 2. May be a result of C. difficile infection.
- 3. Excludes regimens that effectively control bowel movements without evidence of "accidents".
- 4. Check for padding (chux or towels for bedding), diapers, ostomy devices/supplies, soiled clothing.
- 5. Ask caregiver/aide/laundry person.
- 6. Look at bathroom and inquire for use of meds that might cause loose stools (i.e. course of antibiotics that is now complete and not on medication profile).
- Consider cognition related to ability to recognize need to evacuate bowels or awareness of location of toilet.
- 8. When incontinence is driven by cognitive, mobility or self care issues (such as management of clothing) consider referral to therapy services to address these issues.

M1630 Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay, or b) necessitated a change in medical or treatment regimen? | 0 - Patient does not have an ostomy for bowel elimination. | 1 - Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen. | 2 - The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen. | Item Intent | Identifies whether the patient has an ostomy for bowel elimination and, if so, whether the ostomy was related to a recent inpatient stay or caused a change in medical treatment plan.

Optimal Question

SOC

Time Points Item(s)

ROC

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• Have you had, or are you having, any problems with your ostomy or your bowels? Have you been in the hospital or had any treatment changes recently because of it?

Optimal Strategy/Technique

- Inspect patient for presence of ostomy.
- Assess stoma, observe for skin changes, irritation, excoriation.
- Determine if ostomy is reason for discharge from inpatient facility or treatment treatment within the past 14 days from referral information.
- Review history and physical.
- Call hospital or doctor's office for information.

- Determine "past 14 days" by looking at a calendar. Determine the day of the week for SOC/ROC or followup visit. Look back to the same day 2 weeks previous. A change in TX regimen or facility discharge due to of ostomy issues occurring on or during these days are "the past 14 days".
- 2. Consider any type of ostomy for bowel elimination (e.g., colostomy, ileostomy, etc.).
- 3. Excludes an ostomy that has been reversed.
- 4. Patients with longstanding ostomies may not report changes or irritation as they have learned how to manage the ostomy.

M1700 Cognitive Functioning: Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

0 - Alert/oriented,	able to focus a	nd shift attention	, comprehends and	d recalls task directions
independently	' .			

- ☐ 1 Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.
- 2 Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.
- 3 Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- ☐ 4 Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

Item Intent

Identifies the patient's current (at the time of the assessment and in the preceding 24 hours) level of cognitive functioning, including alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

Time Points Item(s)

SOC ROC DC

Optimal Question

- Ask caregivers: Does patient need reminders about taking meds, getting dressed, or bathing, etc.?
- Does he ask the same question or tell the same story multiple times?
- Is he easily distracted?

Optimal Strategy/Technique

- Ask patient to carry out a series of two or three simple instructions and observe response.
- Observe how patient responds to questions regarding current health and past history, medications, names of family and friends, time of day, and ability to stay focused on conversation.
- Verify behavior with family.

- 1. Assessment identifies status at the time of the assessment and in the preceding 24 hrs.
- 2. NOTE: Asking the patient a direct question about his/her own "cognitive function" is not the best assessment strategy.
- 3. Sleep habits, appetite changes and weight changes are relevant to determining current mental status.
- 4. Avoid jumping to conclusions: good social skills and grooming may or may not be indicative of appropriate cognitive function.
- 5. Note distractibility and need to repeat directions.
- 6. Observing ADLs provides an opportunity to determine the patient's ability to comprehend and recall task directions and whether cues, reminders or directions for specific tasks are needed in non-stressful situations.
- 7. Explore reports of "forgetfulness." A patient who uses/needs written reminders to remember events or perform tasks might not be accurately described as a Response 0.
- 8. Appropriate response selection should be apparent by end of visit but may require more than one visit.
- 9. Perform a mini mental status exam http://www.minimental.com/ or a clock drawing test http://www.healthcare.uiowa.edu/igec/tools/cognitive/clockDrawing.pdf if uncertain of cognitive functioning.
- Evaluate for OT and ST services for cognitive therapy and/or psychiatric nursing services and MSW.

M1710	When Confused (Reported or Observed Within the Last 14 Days): 0 - Never 1 - In new or complex situations only 2 - On awakening or at night only 3 - During the day and evening, but not constantly 4 - Constantly NA - Patient nonresponsive	M1
Item Inte	ent the time of day or situations when the patient experienced confusion, if at all.	
	ints Item(s)	

Optimal Question

- Ask the patient: In the last two weeks, did you feel confused at times? If so, when did it happen?
 What was going on when you felt that way? Is this new?
- Ask the caregiver: In the past two weeks have there been times when you think the patient has been confused? Did you notice any changes in the hospital or with his/her new medications?

Optimal Strategy/Technique

- Assessment strategies include interviewing and probing for the patient's perception of their mood and feelings.
- Question family/caregivers as well as the patient.
- Ask patient to identify people in pictures that are displayed.
- Determine if a medication has been prescribed to treat confusion.

Tips

- Assessment identifies status within the last 14 days.
- 2. Conduct a medication regimen review to ascertain if confusion may be related to a drug-to-drug interaction or side-effect(s).
- 3. Confusion relates primarily to orientation.
- 4. Differentiate between confusion, cognition, and anxiety before answering.
- 5. Focus on when patient experiences a deficit in orientation to person, place, time, or situation.
- 6. Note thought processes and behavior in the patient's responses.
- 7. Note attention span. Probe for evidence of recent memory decline.
- 8. Report any episodes of confusion without regard to the cause or potential relevance of the confusion to the episode.
- 9. If the patient has been hospitalized in the past two weeks, especially in ICU or CCU, the patient is likely to have experienced confusion/delirium.
- 10. Sleep habits, appetite changes, and weight changes are relevant to determining current mental status.
- 11. Diagnoses of delirium and dementia are most frequent causes of confusion.
- 12. "Non-responsive" means the patient is unable to respond, has reflexive or involuntary responses only or patient responds in a way that you can't make a clinical judgment about level of orientation.
- 13. Consider both verbal and nonverbal responses.
- 14. Evaluate for referral to rehab services, psychiatric services and MSW when appropriate.

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M1720	When Anxious (Reported or Observed Within the Last 14 Days): O - None of the time 1 - Less often than daily 2 - Daily, but not constantly 3 - All of the time NA - Patient nonresponsive	M1
Item Int	ent s the frequency with which the patient has felt anxious within the past 14 days.	
	pints Item(s) ROC DC	

Optimal Question (s)

- In the last 2 weeks, do you find yourself worrying about things? Have feelings of nervousness? Wake up at night with things on your mind? If yes, how often?
- Ask open-ended questions. (e.g. "What are you worried about?)

Optimal Strategy/Technique

- Assessment strategies may include interviewing and probing for the patient's perception of their mood and feelings.
- Observe behavior during interview.
- Observe for repetitive behavior and facial expressions.

- 1. Assessment identifies status within the past 14 days.
- 2. Interview the family/caregiver.
- 3. Worry becomes anxiety when it is a barrier to appropriate behavior, choices, normal activity or learning.
- 4. Anxiety can be an apprehension about an uncertain future, real or imagined, situations where there is a threat to personal safety and security or anything that makes life less predictable or causes one to feel less in control over the direction of one's life.
- 5. Someone on anti-anxiety medications can still experience anxious feelings. Determine if they do.
- 6. Report any episodes of anxiety without regard to the cause or potential relevance of the anxiety to the episode.
- 7. Note thought processes and behavior in the patient's responses.
- 8. Sleep habits, appetite changes and weight changes are relevant to determining current neuro/emotional status.
- 9. If a patient is diagnosed with COPD, anxiety may result from feeling of breathlessness.
- 10. "Non-responsive" means the patient is unable to respond, has reflexive or involuntary responses only or the patient responds in a way that you can't make a clinical judgment about level of orientation.
- 11. Consider both verbal and nonverbal responses.
- 12. Consider referral to psychiatric nursing services/MSW when appropriate.

M1730 Depression Screening: Has the patient been screened for depression, using a standardized depression screening tool? □ 0 - No 1 - Yes, patient was screened using the PHQ-2© scale. (Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems") More than Nearly N/A Not at all Several days half of the every day PHQ-2© Unable to 0-1 day2-6 days days 12 - 14respond 7 – 11 days days a) Little interest of pleasure in \square 1 □ 3 \Box 0 \square 2 □na doing things b) Feeling down, depressed, or \square 0 □ 1 \square 2 □ 3 ☐ na hopeless? 2 - Yes, with a different standardized assessment-and the patient meets criteria for further evaluation for depression. 3 - Yes, patient was screened with a different standardized assessment-and the patient does not meet criteria for further evaluation for depression. Item Intent Identifies if the home health agency screened the patient for depression using a standardized depression screening tool. CMS does not mandate that clinicians conduct depression screening for all patients, nor is there a mandate for the use of the PHQ-2© or any other particular standardized tool. This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation. Time Points Item(s) SOC ROC Optimal Question(s) Did you use either a standardized assessment tool or the PHQ-2© to screen for depression? Tell me about your life/situation and how you feel now as compared to last year. Use symptoms of depression as direct questions for further clarification. Optimal Strategy/Technique Observe and interview patient, family/caregiver. Observe mood, energy, affect. Check for antidepressant medications. Consider taking more than one visit to complete depression assessment. Leave questions with patient/caregiver for consideration at next visit. **Tips** 1. Assess for medication side effects that may cause depression.

Conduct depression screening with the screening tool and at intervals defined by agency policy/practice, identify scores which indicate the need for further evaluation, and develop an appropriate plan of action/interventions in collaboration with the physician.

- 3. Men over 55 present signs/symptoms of depression different than women; namely anger and withdrawal.
- 4. Do not assume patients on antidepressants are effectively managed.
- 5. Note the high incidence of depression among heart failure (30%+) and diabetic and COPD patients.
- 6. Anti-depressants take on average 6 weeks to show sustained improvement in symptoms.
- 7. Long term anti-depressants may need to be changed or dosage adjusted if S&S are reported as recurring.
- 8. Consider both verbal and nonverbal responses, patient appearance, and condition of environment.
- 9. Document findings and plan for management of depressive symptoms in a consistent location of the record for easy retrieval at the transfer and discharge Time Points.
- 10. The results of PHQ-2 row a and b are for agency use only and will not be encoded and transmitted.
- 11. Based on results of screening, consult physician and develop interventions for further evaluation or monitor and treat current condition.
- 12. Evaluate need for referral to psychiatric nursing services and/or MSW.

M1730 Process Implications: Depression screening

Clinical Recommendations

- Develop/update policies/practices for depression screening including who will do, how often and care practices for further evaluation/follow-up action when indicated by results of the screening and/or patient status.
- Determine scoring parameters for standardized tool indicative of need for further evaluation based on tool selected (PHQ-2 or other standardized).
- Ensure that policies are in place for physician notification when signs of depression present.
- Ensure that policies address actions if patient fails to respond to antidepressant medications, treatment plan.

Operational Recommendations

- Choose a depression screening tool to be used (PHQ-2 or select another <u>standardized</u> depression assessment tool).
- Train all clinicians in proper conduct of depression screening.
- Provide a template of potential interventions when further evaluation, monitoring of current status or adjustments in current treatment or indicated.
- Provide list of agency (i.e. referral to MSW) or local resources for patients requiring further evaluation.
- Designate a consistent place in record to place information so it can be easily accessed at the transfer to Inpatient Facility and Discharge time points.
- Ensure collaboration with the physician in care planning.
- Assign responsibility for concurrent and/or retrospective record review for evidence of compliance with best practice.

M1740 Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week (Reported or Observed): (Mark all that apply.) □ 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc. 4 - Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects) 5 - Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions) 6 - Delusional, hallucinatory, or paranoid behavior 7 - None of the above behaviors demonstrated Item Intent Identifies specific behaviors associated with significant neurological, developmental, behavioral or psychiatric disorders. Time Points Item(s)

SOC ROC **Optimal Question**

Ask caregiver if they saw/noticed any of the behaviors within the last week. Use words they can understand.

Optimal Strategy/Technique

Interview caregiver.

DC

- Review referral information.
- Observe for behaviors that are of concern for safety or social environment during assessment or that may have occurred in the recent past.
- Determine if patient is on any medication to control any behaviors.

- When evaluating, key in on the first two words used prior to the colon in items 1 through 4 (i.e. memory deficit, impaired decision making, etc.) to identify behaviors/actions of concern for the patient's safety or social environment with serious implications for care and care planning that occur at least weekly.
- 2. Item is focused on symptoms and behavior not diagnosis. Example: A patient who smokes while on oxygen / patient who fails to take important medications (e.g. insulin) although functionally able to do so.
- 3. Include for consideration in response 1 those with memory deficits who:
 - a. Require supervision of ADL/IADL for safe performance or completion of task
 - b. Require supervision or assistance with medication or equipment
- 4. Include for consideration in response 2 those who:
 - a. Demonstrate poor safety awareness (e.g. leave walker on other side of room and use furniture and walls for balance because "I don't need it," etc.)
- 5. Assessment includes health status on the day of assessment and the recent past.
- 6. At discharge, evaluate whether these behaviors which may have been present at SOC, are still present.
- 7. Assess the effectiveness of the interventions from the POC implemented during episode of care to reduce and manage these behaviors.
- Determine if any of these behaviors continue to have serious implications for care and care planning and select the corresponding response.
- Evaluate need for referral to psychiatric nursing services and/or MSW.

Optimal Question

• Ask the caregiver if the patient does anything to make them worry about the safety of the patient or themselves and how often this happens.

Optimal Strategy/Technique

- Observe patient behavior and cognition: e.g., reaction to disagreements, stress, conflict, wandering, sleeplessness, etc.
- Upon observation and assessment, note evidence that the patient engages in verbal abuse, threatening or risky behavior to self, caregivers, staff.
- Interview caregivers using examples from response selections for M1740 and determine how
 often patient displays behaviors that would jeopardize their safety or the social environment or
 their ability to achieve their care plan goals.
- Observe caregiver for signs of being overcautious, fearful, or reticent when interacting with patient.

- 1. Consider whether behavior is within generally accepted norms.
- 2. This item reports the frequency of any behaviors that would jeopardize the patient's safety, disrupt his social environment, impact caregivers, or create barriers to achieving care plan goals and includes:
 - a. Behaviors identified in M1740.
 - Any other behavior considered symptomatic of neurologic, cognitive, behavioral, developmental or psychiatric disorders fitting the above criteria (i.e., sleeplessness, getting lost in familiar places, "sundowning", agitation, wandering, aggression, combativeness, etc.).
- 3. Provide specific supporting documentation in the record.
- 4. If multiple problems are exhibited, respond based on the total frequency of all behaviors.
- 5. Assessment includes health status on the day of assessment **and** the recent past.
- 6. Evaluate for need for MSW.

M175	Is this patient receiving Psychiatric Nursing Services at home provided by a qualified psychiatric nurse? □ 0 - No □ 1 - Yes
Item Intent Identifies whether the patient is receiving psychiatric nursing services at home as provided by a qualified psychiatric nurse. "Psychiatric nursing services" address mental/emotional needs; a "qualified psychiatric nurse" is so qualified through educational preparation, certification, or experience.	
	Points Item(s) ROC
Optimal Question	
•	Are psychiatric nursing services ordered on the home health plan of care being provided by your agency?
Optimal Strategy/Technique	
•	Review plan of care and nursing notes.
Tips	
1.	Psychiatric nursing is limited to service provided by your agency, listed on the plan of care, and provided by a "qualified psychiatric nurse".

- 2. Evaluate need based on response to M1700-1745 neuro/emotional/behavioral status.
- 3. Refer to Medicare Benefit Policy Manual, Chapter 7, Section 40.1.2.15, http://www.cms.hhs.gov/manuals/Downloads/bp102c07.pdf

W1800 Grooming: Current ability to tend safely to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care). | 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods. | 1 - Grooming utensils must be placed within reach before able to complete grooming activities. | 2 - Someone must assist the patient to groom self. | 3 - Patient depends entirely upon someone else for grooming needs.

Item Intent

Identifies the patient's ability to tend to personal hygiene needs, excluding bathing, shampooing hair, and toileting hygiene.

The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely perform grooming, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:

- physical impairments (e.g., limited range of motion, impaired balance)
- emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)
- sensory impairments, (e.g., impaired vision or pain)
- environmental barriers (e.g., accessing grooming aids, mirror and sink)

Time Points Item(s)

SOC ROC DC

Optimal Question(s)

- What help do you need to wash you face and do your hair and mouth care?
- How do you get the items you need to wash up and brush your hair/teeth?
- Do you get them yourself?

Optimal Strategy/Technique

- Note location of grooming items and ease of access to them.
- Note cleanliness status of hands and face, teeth, condition of beard and hair.
- Observe washing hands and/or face.
- Use all reported and observed information to make necessary inferences about patient's ability to gather the equipment for and perform their grooming tasks.
- Verify patient reported information with caregiver.

- 1. Assessment includes both gathering equipment and performing grooming activities.
- 2. Consider the frequency with which the selected tasks are necessary.
- 3. Ability to do more frequently performed activities and inability to perform less frequently performed activities should be considered.
- 4. Consider location and accessibility of grooming items.
- 5. This item does not include shampooing hair.
- 6. Evaluate need for OT or Aide services if score "2" or higher and there is a deficit in caregiver availability.

1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient.

Item Intent

Identifies the patient's ability to dress upper body, including the ability to obtain, put on and remove upper body clothing. Assess ability to put on whatever clothing is routinely worn. This specifically includes the ability to manage zippers, buttons, and snaps if these are routinely worn.

The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely dress the upper body, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:

- physical impairments (e.g., limited range of motion, impaired balance)

2 - Someone must help the patient put on upper body clothing.

3 - Patient depends entirely upon another person to dress the upper body.

- emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)
- sensory impairments, (e.g., impaired vision or pain)
- environmental barriers (e.g., stairs, narrow doorways, location of bathroom or laundry)

Time Points Item(s)

SOC ROC FU DC

Optimal Question

- Do you have difficulty dressing?
- Have you changed what you wear to make it easier to get dressed?
- Where are your clothes located?
- What type of tops do you normally wear?
- Do you have difficulty putting on your shirt?
- Have you changed the location of your clothes?

Optimal Strategy/Technique

- Select response based on ability to perform the majority of tasks involved in dressing upper body.
- Note location of clothes and ability to safely carry any item.
- Have patient demonstrate how to takes shirt off and put them back on when assessing blood pressure.
- Use all reported and observed information to make necessary inferences about patient's ability to obtain, put on, and take off upper body clothing.
- Observe buttoning/zipping.
- Verify patient reported information with caregiver.

- 1. Score ability for the day of assessment (the time of the visit and in the 24 hrs preceding the visit).
- 2. "Assistance" refers to any kind of direct human intervention; verbal cues, supervision, contact guard, hands on, etc.

- 3. Score level of ability disregarding temporary environmental modifications that exist to facilitate access in response to a "bad day".
- 4. Select response based on ability to safely dress in the majority of upper body dressing items which includes:
 - Put on and remove clothing of the style and type routinely worn.
 - Manage buttons, zippers, snaps, etc. if part of clothing routinely worn.
 - Apply protective and supportive devices.
 - Access clothing and devices where they are stored.
- 5. Exclude consideration of dressing in stages when due to shortness of breath.
- 6. Evaluate need for OT or Aide services if score "2" or higher and there is a deficit in caregiver availability.

M1820 Current Ability to Dress Lower Body safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes: 0 - Able to obtain, put on, and remove clothing and shoes without assistance. 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient. 2 - Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes. 3 - Patient depends entirely upon another person to dress lower body.

Item Intent

Identifies the patient's ability to dress lower body, including the ability to obtain, put on and remove lower body clothing. Assess ability to put on whatever clothing is routinely worn.

The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely dress the lower body, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:

- physical impairments (e.g., limited range of motion, impaired balance)
- emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)
- sensory impairments, (e.g., impaired vision or pain)
- environmental barriers (e.g., stairs, narrow doorways, location of bathroom or laundry)

Time Points Item(s)

SOC ROC FU DC

Optimal Question(s)

- Do you have difficulty dressing?
- Have you changed what you wear to make it easier to get dressed?
- Where are your clothes located?
- What do you wear on your feet?
- Do you have difficulty putting on pants, stockings, or shoes?

Optimal Strategy/Technique

- Note location of clothes and ability to safely carry any item.
- Have patient demonstrate how to takes shoes and socks off and put them back on when assessing condition of feet.
- Use all reported and observed information to make necessary inferences about patient's ability to obtain, put on, and take off lower body clothing.
- Verify patient reported information with caregiver.

- 1. Score ability for the day of assessment (the time of the visit and in the 24 hrs preceding the visit).
- 2. "Assistance" refers to any kind of direct human intervention; verbal cues, supervision, contact guard, hands on, etc.
- 3. Score level of ability disregarding temporary environmental modifications that exist to facilitate access in response to a "bad day".
- 4. Select response based on ability to safely dress in the majority of lower body dressing items which includes:
 - Put on and remove clothing and shoes/slippers of the style and type routinely worn.
 - Manage buttons, zippers, snaps, etc if part of clothing routinely worn.
 - Apply protective and supportive devices.
 - Access clothing and devices where they are stored.
- 5. Exclude consideration of dressing in stages when due to shortness of breath.
- 6. Evaluate need for OT or Aide services if score "2" or higher and there is a deficit in caregiver availability.

M1830 Bathing: Current ability to wash entire body safely. Excludes grooming (washing face, washing hands, and shampooing hair). 0 - Able to bathe self in shower or tub independently, including getting in and out of tub/shower. 1 - With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower. 2 - Able to bathe in shower or tub with the intermittent assistance of another person: (a) for intermittent supervision or encouragement or reminders, OR (b) to get in and out of the shower or tub, OR (c) for washing difficult to reach areas. 3 - Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision. 4 - Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode. 5 - Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person throughout the bath. 6 - Unable to participate effectively in bathing and is bathed totally by another person. Item Intent Identifies the patient's ability to bathe entire body and the assistance that may be required to safely bathe, including transferring in/out of the tub/shower. The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely bathe, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by: - physical impairments (e.g., limited range of motion, impaired balance)

- emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)
- sensory impairments, (e.g., impaired vision or pain)
- environmental barriers (e.g., stairs, narrow doorways, location of bathroom or laundry)

Time Points Item(s)

SOC ROC FU DC

Optimal Question(s)

- Are you able to get into your tub or shower? Or if caregiver, are you able to get the patient into the tub or shower?
- What keeps you from bathing in the tub/shower?
- Does anyone help you to bathe?

Optimal Strategy/Technique

- Use all reported and observed information to make necessary inferences about patient's ability to wash his/her body.
- Note level of hygiene and if poor, determine cause (choice versus physical or mental ability).
- Note location of tub/shower, barriers to access and barriers to use (no running water in tub).
- Observe patient transfer to tub/shower.
- Have patient demonstrate how he/she washes feet and back.
- Score item based on ability to get into and out of the tub/shower by any safe means with the current bathroom and equipment setup regardless of whether they routinely do it.
- Verify patient reported information with caregiver.

- 1. Score ability for the day of assessment (the time of the visit and in the 24 hrs preceding the visit).
- 2. "Assistance" refers to any kind of direct human intervention; verbal cues, supervision, contact guard, hands on, etc.
- 3. Bathing item now includes the ability to transfer in and out of tub/shower.
- 4. Notice availability/use of adaptive equipment/assistive device.
- 5. Select response 0 if safely able to BOTH bath **and** transfer safely without equipment/devices or human intervention.
- 6. Bathing item has been expanded to discern those patients that can safely bathe outside the tub/shower by themselves (response 4) and those that require some human intervention (response 5).
- 7. If there is a need for the <u>presence</u> of a caregiver throughout due to severity of dementia/cognition, score response 3.
- 8. Select response 4, 5, or 6 if bathing facilities are nonfunctioning or not safe.
- 9. Determine score based on physical and cognitive ability to use tub/shower, not on alternative uses of tub (e.g. storage place).
- 10. Base selection on the <u>need</u> to use assistive devices when bathing.
- 11. Always consider safety.
- 12. Exclude bathing-related tasks such as gathering supplies, preparing bath water, or drying off after the bath.
- 13. Evaluate need for PT, OT or Aide services if score 2 or higher and there is a deficit in caregiver availability.

Item Intent

Identifies the patient's ability to <u>safely</u> get to and from and transfer on and off the toilet or bedside commode.

The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely perform toilet transferring, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:

- physical impairments (e.g., limited range of motion, impaired balance)
- emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)
- sensory impairments, (e.g., impaired vision or pain)
- environmental barriers (e.g., stairs, narrow doorways, location of bathroom)

Time Points

SOC ROC FU DC

Optimal Question

How and where do you normally toilet? Use the bathroom? Use words the patient can understand. Do you do anything different at night?

Optimal Strategy/Technique

- Show me how you get into your bathroom and on/off the toilet. Show me how you use your bedside commode.
- Verify patient reported information with caregiver.

- Score ability for the day of assessment (the time of the visit and in the 24 hrs preceding the visit).
- 2. "Assistance" refers to any kind of direct human intervention; verbal cues, supervision, contact guard, hands on, etc.
- 3. Consider ability to get to bathroom whether by walking, wheelchair, etc.
- 4. Consider ability to climb stairs if bathroom on second floor.
- 5. Note availability/use of adaptive equipment and assistive device.
- 6. Exclude hygiene and managing clothing management are not included.
- 7. Toilet transfer ability must be determined even when a patient does not use a toilet due to the presence of an indwelling urinary catheters and a bowel ostomy.
- 8. Scoring is based on the level of assistance needed, regardless of whether that assistance is available.
- 9. Evaluate need for PT, OT or HHA when scoring 1 or higher.
- 10. If required for safe function, service animals should be considered an assistive device.

M1845 Toileting Hygiene: Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment. □ 0 - Able to manage toileting hygiene and clothing management without assistance. □ 1 - Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient. □ 2 - Someone must help the patient to maintain toileting hygiene and/or adjust clothing. □ 3 - Patient depends entirely upon another person to maintain toileting hygiene.

Item Intent

Identifies the patient's ability to manage personal hygiene and clothing when toileting.

The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely perform toileting hygiene, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:

- physical impairments (e.g., limited range of motion, impaired balance)
- emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)
- sensory impairments, (e.g., impaired vision or pain)
- environmental barriers (e.g., stairs, narrow doorways, location of bathroom or laundry)

Time Points Item(s)

SOC ROC DC

Optimal Question

- Can you show me how you manage your clothing when in the bathroom?
- Are you able to clean yourself?

Optimal Strategy/Technique

- Observe patient to determine ability to remove and apply clothing as required for toileting.
- Have patient demonstrate toileting activities if indicated.
- Conduct skin check for cleanliness, rashes.
- Observe for odors indicative of inability to carry out proper toileting hygiene.
- Inspect underwear for signs of soiling.
- Verify patient reported information with caregiver.

- 1. While observing lower back/buttocks assess hygiene.
- 2. Check cleanliness around ostomies.
- 3. Include ability to cleanse around urinary catheter/perineal area.
- 4. Be sure that even if patient can get pants down, they can get them back up.
- 5. Score in accord with the 50% rule: able to perform 50% or more of the functions (e.g., voiding versus bowel hygiene); able to perform functions 50% or more of the time.
- 6. Score ability for the day of assessment (the time of the visit and in the 24 hrs preceding the visit).
- 7. "Assistance" refers to any kind of direct human intervention; verbal cues, supervision, contact guard, hands on, etc.
- 8. Evaluate need for PT, OT, or HHA services when scoring "1" or higher.
- 9. If required for safe function, service animals should be considered an assistive device.

M1850 Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast. □ 0 - Able to independently transfer. □ 1 - Able to transfer with minimal human assistance or with use of an assistive device. □ 2 - Able to bear weight and pivot during the transfer process but unable to transfer self. □ 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person. □ 4 - Bedfast, unable to transfer but is able to turn and position self in bed. □ 5 - Bedfast, unable to transfer and is unable to turn and position self.

Item Intent

Identifies the patient's ability to safely transfer from bed to chair (and chair to bed), or position self in bed if bedfast. The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely transfer, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:

- physical impairments (e.g., limited range of motion, impaired balance)
- emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)
- sensory impairments, (e.g., impaired vision or pain)
- environmental barriers (e.g., stairs, narrow doorways, location of bathroom or laundry)

Time Points Item(s)

SOC ROC FU DC

Optimal Question

- Can you show me how you get from your bed to a chair?
- If bedfast: Can you show me how you turn from side to side?

Optimal Strategy/Technique

- Have patient transfer from bed to chair.
- Include observation of moving from supine position in bed to a sitting position at the bedside, some type of standing, stand-pivot, or sliding board transfer to a chair.
- If bedfast, have patient perform turning and positioning self in bed.
- Verify patient reported information with caregiver.

- 1. Note: transferring for this OASIS item is now limited to a bed to chair/chair to bed transfer and bed mobility (tub, shower, toileting transfers moved to other items).
- 2. Score ability for the day of assessment (the time of the visit and in the 24 hrs preceding the visit).
- 3. "Assistance" refers to any kind of direct human intervention; verbal cues, supervision, contact guard, hands on, etc.
- 4. Remember, the word *SAFELY* when assessing.
- 5. Pushing up with arms does not constitute dependence.
- 6. Consider availability/use of adaptive equipment and assistive device.
- 7. Minimal human assistance:
 - Can include combinations of cueing, environmental set-up and/or hands-on.
 - Equals 25% or less of the total effort by another person.
- 8. A patient who can tolerate being out of bed is NOT bedfast.
- 9. Select "3" for patients who can tolerate being out of bed but are unable to bear weight or pivot (e.g., Hoyer Lift, totally dependent transfer by another person).
- 10. If there is no chair in the room, report patient's ability to move from a supine position in bed to a sitting position at the side of the bed, then to stand, then sit on the nearest available sitting surface (e.g. commode, chair in other room, toilet, etc.).
- 11. If consideration of ability to conduct other transfers (e.g. car) is needed for a patient, performance should be documented in another part of the clinical record and not scored in this item.
- 12. If required for safe function, service animals should be considered an assistive device.

M1860 Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces. 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device). 1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings. 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces. 3 - Able to walk only with the supervision or assistance of another person at all times. 4 - Chairfast, <u>unable</u> to ambulate but is able to wheel self independently. 5 - Chairfast, unable to ambulate and is unable to wheel self. 6 - Bedfast, unable to ambulate or be up in a chair. Item Intent Identifies the patient's ability and the type of assistance required to safely ambulate or propel self in a wheelchair over a variety of surfaces. The intent of the item is to identify the patient's ABILITY, not necessarily actual performance.

Identifies the patient's ability and the type of assistance required to <u>safely</u> ambulate or propel self in a wheelchair over a variety of surfaces. The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely ambulate/locomote, given the current physical and mental/ emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:

- physical impairments (e.g., limited range of motion, impaired balance)
- emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)
- sensory impairments, (e.g., impaired vision or pain)
- environmental barriers (e.g., stairs, narrow doorways, location of bathroom or laundry)

Time Points Item(s)

SOC ROC FU DC

Optimal Question(s)

- Can you show me how you move around the house?
- Do you feel comfortable showing me how you manage the stairs?
- Can you show me how you move about in your wheelchair?
- Can you get up/down stairs?

Optimal Strategy/Technique

- Observe patient ambulating on variety of surfaces, including stairs (do not attempt stairs if it doesn't appear safe).
- · Verify patient reported information with caregiver.

- 1. Safety in performance is a major consideration.
- 2. Score ability for the day of assessment (the time of the visit and in the 24 hrs preceding the visit).
- 3. "Assistance" refers to any kind of direct human intervention; verbal cues, supervision, contact guard, hands on, etc.
- 4. The impact of clinical conditions present on the day of assessment (cognitive impairment, edema, pain, paresis, paralysis, impaired balance, fall risk, etc.) must be identified before responding.
- 5. Additional documentation is needed if patient has the ability to ambulate but is unwilling.
- 6. Patient's who have the ability to walk safely with or without human intervention and also use a wheelchair are scored on their ability to ambulate regardless of how much they use the wheelchair.
- 7. Select Response 0 or 1 when no human intervention is required to safely negotiate any even or uneven surface.
- 8. Select Response 3 when supervision is needed "at all times" or constantly.
- 9. Consider the floor plan of home, the variety of even and uneven surfaces, access to areas routinely used and surfaces to get to the physician's office.
- 10. If required for safe function, service animals should be considered an assistive device.
- 11. Evaluate need for PT, OT, or HHA when score is 2 or more.

M1870 **Feeding or Eating:** Current ability to feed self meals and snacks safely. Note: This refers only to the process of <u>eating</u>, <u>chewing</u>, and <u>swallowing</u>, <u>not</u> preparing the food to be eaten. 0 - Able to independently feed self. ☐ 1 - Able to feed self independently but requires: (a) meal set-up; OR (b) intermittent assistance or supervision from another person; OR (c) a liquid, pureed or ground meat diet. 2 - <u>Unable</u> to feed self and must be assisted or supervised throughout the meal/snack. 3 - Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy. 4 - Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy. 5 - Unable to take in nutrients orally or by tube feeding. Item Intent Identifies the patient's ability to feed him/herself, including the process of eating, chewing, and swallowing food. The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely self-feed, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by: - physical impairments (e.g., limited range of motion, impaired balance - emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear) - sensory impairments, (e.g., impaired vision or hearing, pain) - environmental barriers (e.g., stairs, narrow doorways, location of bathroom or laundry) Time Points Item(s) SOC ROC **Optimal Question** Do you (or does the patient if interviewing the family) have trouble: Chewing or swallowing? With coughing or choking when you eat or drink? Eating certain foods? Require help cutting up your food or feeding yourself? Optimal Strategy/Technique Interview patient and/or family. Observe patient at mealtime. Consider dentition and oral condition.

- Tips Chopping or cutting of food is not considered meal set-up in homes where the culture dictates that the food be chopped or cut before being served, such as in some Asian cultures.
 - 2. Score ability for the day of assessment (the time of the visit and in the 24 hrs preceding the visit).
 - 3. "Assistance" refers to any kind of direct human intervention; verbal cues, supervision, contact guard, hands on, etc.
 - Evaluate need for ST or OT referrals.

Verify patient reported information with caregiver.

Current Ability to Plan and Prepare Light Meals (e.g., cereal, sandwich) or reheat delivered meals safely: 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR (b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission). 1 - Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations. 2 - Unable to prepare any light meals or reheat any delivered meals.

Item Intent

Identifies the patient's physical, cognitive, and mental ability to plan and prepare meals, even if the patient does not routinely perform this task.

The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely perform light meal planning and preparation, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform IADLs. Ability can be temporarily or permanently limited by:

- physical impairments (e.g., limited range of motion, impaired balance)
- emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)
- sensory impairments, (e.g., impaired vision, pain)
- environmental barriers (e.g., stairs, narrow doorways)

Time Points Item(s)

SOC ROC DC

Optimal Question

- If you had to prepare your next meal what <u>could</u> you make and how would you do it?
- What do you prepare when you have no one to make a meal for you?
- Do you know what foods are allowed on your special diet?
- Caregiver question: is the patient able to prepare simple foods?

Optimal Strategy/Technique

Observe patient make a sandwich or heat an item in the microwave.

- 1. Consider ability to select, retrieve, carry, prepare, and get items to table or cooking area for reheating a prepared meal.
- 2. Assessment of "ability" may be in conflict with reporting how the patient actually performs the task on a routine basis. Document differences in clinical record.
- 3. Consider ability to prepare light meals in accord with dietary restrictions.
- 4. Score ability for the day of assessment (the time of the visit and in the 24 hrs preceding the visit).
- 5. "Assistance" refers to any kind of direct human intervention; verbal cues, supervision, contact guard, hands on, etc.
- 6. If required for safe function, service animals should be considered an assistive device.
- 7. Evaluate need for nursing when rehab conducting assessment and patient on therapeutic diet and OT referral.

M1890	Ability to Use Telephone: Current ability to answer the phone safely, including dialing numbers, and <u>effectively</u> using the telephone to communicate.	M18
	0 - Able to dial numbers and answer calls appropriately and as desired.	
	1 - Able to use a specially adapted telephone (i.e., large numbers on the dial, teletype phone for deaf) and call essential numbers.	the
	 2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placi calls. 	ng
	 3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation. 	
	4 - <u>Unable</u> to answer the telephone at all but can listen if assisted with equipment.	
	☐ 5 - Totally unable to use the telephone.	
	□ NA - Patient does not have a telephone.	

Item Intent

Identifies the ability of the patient to answer the phone, dial number, and effectively use the telephone to communicate.

The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely use the telephone, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform IADLs. Ability can be temporarily or permanently limited by:

- physical impairments (e.g., limited range of motion, impaired balance)
- emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)
- sensory impairments, (e.g., impaired vision or hearing, pain)
- environmental barriers (e.g., stairs, narrow doorways)

Time Points Item(s)

SOC ROC DC

Optimal Question

Do you have a phone and can you use it?

Optimal Strategy/Technique

- Consider the patient's physical and cognitive ability to safely complete all tasks associated with telephone use including answering, dialing, and effectively using the telephone to communicate.
- Have the patient demonstrate phone use calling the agency office.
- Call the patient's phone using your cell phone in order to demonstrate answering ability.
- Verify ability to use telephone with caregiver.

- 1. Consider vision, hearing, and cognition.
- 2. Score ability for the day of assessment (the time of the visit and in the 24 hrs preceding the visit).
- 3. "Assistance" refers to any kind of direct human intervention; verbal cues, supervision, contact guard, hands on, etc.
- 4. Select response 1 if they teletype or text.
- 5. Note the location of the phone and its accessibility.
- 6. Evaluate need for ST referral.

M1900 Prior Functioning ADL/IADL: Indicate the patient's usual ability with everyday activities prior to this current illness, exacerbation, or injury. Check only **one** box in each row.

M1900

Functional Area	Independent	Needed Some Help	Dependent
Self-Care (e.g., grooming, dressing, and bathing)	□0	□ 1	□2
b. Ambulation	□0	□1	□ 2
c. Transfer	□0	□1	□ 2
d. Household tasks (e.g., light meal preparation, laundry, shopping	□0	<u> </u>	□2

Item Intent

Identifies changes that have occurred in the patient's ability to perform ADL and IADL activities since the onset of the current illness, exacerbation of a chronic condition, or injury (whichever is most recent) that initiated this episode of care. The intent of the item is to identify the patient's prior ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. This item is used for risk adjustment and can be helpful for setting realistic goals for the patient.

Time	Points	Item	(s)

SOC ROC

Optimal Question

• Were there any self care or household tasks that you (or the patient, if asking caregiver) were unable to do by yourself before this illness? (May need to help the patient/caregiver correctly identify the time frame "prior to this current illness, exacerbation or injury".)

Optimal Strategy/Technique

- Confirm patient reports with caregiver.
- Review medical records and history available from physician, hospital, etc.
- Observe for equipment and home adaptations.
- Take into consideration whether the patient could safely perform activities prior to this illness, exacerbation or injury.

- 1. Conduct the analysis in a way to identify what the patient was capable of doing, regardless of whether the patient chooses to perform the activities (e.g. capable of doing laundry but chose not to).
- 2. Time frame under consideration is the time prior to the current illness, exacerbation or injury that initiated this episode of care.
- 3. If required for safe function, service animals should be considered an assistive device.

M1910 Has this patient had a multi-factor Fall Risk Assessment (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)? | 0 - No multi-factor falls risk assessment conducted. | 1 - Yes, and it does not indicate a risk for falls. | 2 - Yes, and it indicates a risk for falls.

Identifies whether the home health agency has assessed the patient and home environment for characteristics that place the patient at risk for falls. Patients under the age of 65 will be excluded from the denominator of the publicly reported measure. The multi-factor falls risk assessment must include at least one standardized tool that 1) has been scientifically tested on a population of community dwelling elders and shown to be effective in identifying people at risk for falls; and 2) includes a standard response scale. The standardized tool must be appropriately administered as indicated in the

This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.

Time Points Item(s)

SOC ROC

instructions.

Optimal Question

None

Optimal Strategy/Technique

- Conduct a multifactor falls risk assessment as part of the SOC/ROC process.
- Until a multi-factor "validated" standardized tool has been identified, use Tinetti, TUG (Timed Up and Go) or functional reach test, supplemented by an assessment of least one other fall risk factor (e.g. incontinence, polypharmacy).

Tips

- 1. The same person who completes the comprehensive assessment must perform the falls risk assessment in order to respond "yes" to this item.
- Unless the tool the agency uses meets the criteria for standardized and validated, one of the
 components of a multifactor risk assessment must be a standardized and validated assessment
 such as a Tinetti balance test, Timed Up and Go (TUG), functional reach, etc. to qualify for a "yes"
 answer.
- 3. A "No" response effects outcomes for patients 65 years and older.
- 4. Other OASIS items that identify fall risks (e.g., impaired vision) may be used to supplement a multi-factor fall risk assessment but do not constitute a standardized multi-factor fall risk assessment.
- 5. Based on the results of the risk assessment, plan interventions and referrals to rehab services to reduce the specific areas of risk and confirm with the physician.

M1910 Process Implications: Falls risk assessment for patients 65 and older.

Clinical Recommendations

- Reassess fall risk on regular basis in accord with patient condition (not just at OASIS time points).
- Educate patient on fall risks and interventions.
- Conduct review and re-review of "all" medications and consider impact on fall risk.
- Make appropriate referrals (PT, OT, SLP, SN, vision and hearing screening, pharmacist, etc.) to address identified risks.
- Refer for needed environmental modification.

- Establish a plan to address incontinence.
- Carry out positional blood pressure readings.
- Arrange for emergency call/access device (i.e. Lifeline).
- Collaborate with the physician to develop plan to reduce fall risk.

Operational Recommendations

- Determine standardized fall risk assessment components to be used by the agency and results indicating no risk, minimal, moderate, and high risk parameters.
- Educate all clinicians in the Tinetti, Timed Up and Go (TUG), or functional reach assessment (or other standardized and validated assessment tool), supplemented by other fall risks, to qualify agency as having valid falls risk tool.
- Ensure that the falls risk assessment is an integral part of the admission packet used by the assessing clinician.
- Develop a template of potential interventions consistent with areas of risk.
- Determine consistent location to record implementation of interventions for easy retrieval at transfer and discharge not to inpatient facility time points.

M2000 Drug Regimen Review: Does a complete drug regimen review indicate potential clinically significant medication issues, e.g., drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance? □ 0 - Not assessed/reviewed [Go to M2010] □ 1 - No problems found during review [Go to M2010] □ 2 - Problems found during review □ NA - Patient is not taking any medications [Go to M2040] Item Intent Identifies if a review of the patient's medications indicated the presence of potential clinically significant problems. This item captures information for calculation of a process measure to identify best practices

related to medications. Time Points Item(s)

SOC ROC

Optimal Question

- Do you have a list of the current medications from the doctor or list from the hospital?
- Do you have any feelings of confusion or dizziness or an upset stomach that you think might be related to your medications?
- Do you have all the medications you are supposed to be taking?
- Do you take all the medications you are supposed to?

Optimal Strategy/Technique

- When calling patient to set appointment, ask to get all of their medications out for the agency staff to review.
- Show me all of the medications you are taking, including those prescribed by your physician and any over the counter, creams, vitamins, herbs, potions, and injectables?
- Have the patient demonstrate where the meds are stored, how they get them out of the container, and what they do to remember to take them.
- Collaborate and/or conduct a complete medication review following agency process to identify
 potential clinically significant medication issues. Process for contraindication review should
 support all clinicians (FT/PT/WE); For example: website (drugstore.com, epocrates.com); drug
 books; generic/homegrown lists; software exclusion drug check; call the pharmacist, etc.

- 1. Reconcile medications, review list for potential clinically significant problems including drug-drug interactions, document the process, collaboration and results of review. This can be done with the assistance of other clinicians or resources, but it is the responsibility of the individual completing the document to confirm it has been done and to complete the response representing the results of the review. If this assistance impacts the date assessment completed, item M0090 should be updated accordingly.
- 2. Based on results, develop interventions, consult the physician, and work to resolve issues.
- 3. It is not necessary to report medication problems that are identified and resolved by the agency staff prior to completion of the assessment.
- 4. Carefully evaluate whether an issue meets the definition of clinically significant (examples are listed above in item description).
- 5. Look for different pharmacies/physicians and dates on medication bottles.
- 6. Call the pharmacies for a current list of meds.
- 7. Look at medication bottles, the number of refills used, the number of pills left to assess appropriate usage.
- 8. Consider dietary restriction related to medications (e.g., limitation on greens when on Coumadin).

M2002 Medication Follow-up: Was a physician or the physician-designee contacted within one calendar day to resolve clinically significant medication issues, including reconciliation? □ 0 - No □ 1 - Yes Item Intent

Identifies if potential clinically significant problems identified through a medication review were addressed with the physician within one calendar day following identification of medication issue(s).

This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.

Time Points Item(s)

SOC ROC

Optimal Question

 Did I (or agency person I collaborated with) notify the physician/designee of the medication issue and receive a response with further advice or instructions within one calendar day?

Optimal Strategy/Technique

• Contact physician via any appropriate means respecting physician preference ASAP (eg, phone, fax, email) monitoring for physician response within 1 calendar day.

Tips

- 1. Carefully evaluate whether an issue meets the definition of "clinically significant".
- 2. Initiate flow sheet or software applications to document clinically significant medication issues, reports, and response in real time for easy retrieval at the transfer and discharge to inpatient facility time points.
- 3. The two-way physician communication and reconciliation must be completed by the end of the next calendar day after the problem was identified and within 5 days of the SOC and 2 days of ROC.
- 4. Communication to/from the physician or designee can be directly to/from the physician or indirectly through physicians' office staff on behalf of the physician.

M2002 Process Implications: Medication follow-up

Clinical Recommendations

- Educate all clinicians on definition of "clinically significant medication issues".
- Establish agency process for contraindication review to support all clinicians (FT/PT/WE) in order to identify medication issues. For example: website (drugstore.com), drug books, generic list, software exclusion drug check, call the pharmacist.
- Establish/reinforce/monitor timely communication method/process for when collaboration is required to complete the task and/or the physician needs to be contacted.

Operational Recommendations

- Educate physicians on new home health process measures and their importance in improved patient care.
- Ask physicians to identify what procedures for notification and response would best meet their needs (e.g., faxes or secure e-mail versus phone calls, response to clinical supervisor at the agency).
- Educate all clinicians on expectations regarding physician notification of significant medication issues using SBAR (Situation-Background-Assessment-Recommendation) technique for communication.
- Educate agency clinicians on how to use effective physician communication protocols.

- Establish processes to ensure prompt reporting of issues (during home visits whenever possible) to both physicians and agency clinical staff.
- Consider establishment of processes that will reduce physician burden, such as physician call backs to clinical staff at the agency office when appropriate.
- Create actions to be taken when physicians fail to respond promptly (e.g., call backs, request for physician office staff intervention).
- Ensure that software captures information about physician reporting and responses or create a flow sheet for recording reports/physician responses.
- Establish record review process to determine compliance with processes and accuracy of response.
- Revise processes as practice evolves.
- Ensure clinicians have access to know when last OASIS assessment was completed.

M2004 **Medication Intervention:** If there were any clinically significant medication issues since the previous OASIS assessment, was a physician or the physician-designee contacted within one calendar day of the assessment to resolve clinically significant medication issues, including reconciliation? \bigcap 0 – No □ 1 – Yes NA – No clinically significant medication issues identified since the previous OASIS assessment Item Intent Identifies if potential clinically significant problems such as adverse effects or drug reactions identified

at the time of the most recent OASIS assessment or after that time were addressed with the physician.

This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.

Time I	oints	ltem((s)
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TRF DC

Optimal Question(s)

- Has this patient had any significant medication issues since the last OASIS?
- Is there documentation of physician contact and response to significant medication issues?

Optimal Strategy/Technique

Use flow sheet or software applications initiated at SOC or read notes to determine if there were any significant medication issues on or since the last OASIS assessment.

Tips

- Determine when last OASIS assessment was completed to establish "look back" period for reporting this information.
- 2. Carefully evaluate whether an issue meets the definition of "clinically significant".
- 3. Use flow sheet or software applications developed to capture this information at this transfer or discharge not to inpatient facility assessment time point.
- 4. Select "YES" when the two-way physician communication and reconciliation was completed by the end of the next calendar day after the problem was identified.
- 5. Communication to/from the physician or designee can be directly to/from the physician or indirectly through physician office staff on behalf of the physician.

M2004 Process Implications: Medication Intervention

Clinical Recommendations

- Educate all clinicians on definition of "clinically significant medication issues".
- Establish agency process for contraindication review to support all clinicians (FT/PT/WE) in order to identify medication issues. For example: website (drugstore.com), drug books, generic list, software exclusion drug check, call the pharmacist.
- Establish/reinforce/monitor timely communication method/process for when collaboration is required to complete the task and/or the physician needs to be contacted.

Operational Recommendations

- Educate physicians on new home health process measures and their importance in improved patient care.
- Ask physicians to identify what procedures for notification and response would best meet their needs (e.g., faxes or secure e-mail versus phone calls, response to clinical supervisor at the agency).

- Educate all clinicians on expectations regarding physician notification of significant medication issues using SBAR (Situation-Background-Assessment-Recommendation) technique for communication.
- Educate agency clinicians on how to use effective physician communication protocols.
- Establish processes to ensure prompt reporting of issues (during home visits whenever possible) to both physicians and agency clinical staff.
- Consider establishment of processes that will reduce physician burden, such as physician call backs to clinical staff at the agency office when appropriate.
- Create actions to be taken when physicians fail to respond promptly (e.g., call backs, request for physician office staff intervention).
- Ensure that software captures information about physician reporting and responses or create a flow sheet for recording reports/physician responses.
 - Establish record review process to determine compliance with processes and accuracy of response. Revise processes as practice evolves.

M2010 Patient/Caregiver High Risk Drug Education: Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur? □ 0 − No □ 1 − Yes □ NA − Patient not taking any high risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications

Item Intent

Identifies if clinicians instructed the patient and/or caregiver about all high-risk medications the patient takes. High-risk medications are those identified by quality organizations (Institute for Safe Medication Practices, JCAHO, etc.) as having considerable potential for causing significant patient harm when they are used erroneously.

This item is targeted to high-risk medications as it may be unrealistic to expect that patient education on all medications occur on admission and failure to provide patient education on high-risk medications such as hypoglycemics and anticoagulants (and others) at SOC/ROC could have severe negative impacts on patient safety and health.

This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.

Time Points Item(s)

SOC ROC

Optimal Question

• If a high risk medication is listed, did I or someone I collaborated with provide instruction on special precautions to the patient/caregiver?

Optimal Strategy/Technique

- Conduct drug review and identify high risk drugs on the initial and ROC visits.
- Capture medication education within documentation.
- Use the 5 day window for SOC and 2 days for ROC, as appropriate to the patient's needs, to complete high risk drug education and respond to item.

Tips

- Carry a regularly updated list of medications determined to be high risk by your agency.
- 2. Carry teaching sheets for high risk meds.
- 3. Educate on new medications and reinforce medication teaching on each visit.

Clinical Strategy

- Establish agency policies defining the parameters for content, timing and responsibility (based on state practice acts) for high risk drug education at SOC/ROC and throughout the course of care.
- Provide list of high risk medications to all staff responsible for medication education and keep it current.
- Create/revise necessary educational material including teaching sheets and teaching tools.
- Ensure compliance of those with responsibility to provide drug education.

Operational Strategy

- Establish and keep current a realistic high risk medication list specific to the agency service delivery model based on an established authoritative resource such as the Institute for Safe Medication Practices or Joint Commission's High Alert Medication list, etc.
- Investigate state practice acts for rehab services to determine ability to participate in this practice.
 Develop alternate process if contraindicated.
- Plan for regular chart audits to ensure compliance with this best practice.

M2015 Patient/Caregiver Drug Education Intervention: Since the previous OASIS assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, drug reactions, and side effects, and how and when to report problems that may occur? □ 0 − No

M2015

Item Intent

□ 1 – Yes

□ NA – Patient not taking any drugs

Identifies if clinicians instructed the patient/caregiver about how to manage medications effectively and safely.

Drug education interventions for M2015 should address all medications the patient is taking – prescribed and over-the-counter – by any route.

Effective, safe management of medications includes knowledge of effectiveness, potential side effects and drug reactions, and when to contact the appropriate care provider.

This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.

Time Points Item(s)

TRF DC

Optimal Question(s)

- What kinds of things have you learned about your medications?
- Has any agency provider provided medication instruction (as identified above in the item description) for non high risk meds since the previous OASIS assessment?
- Has medication education been provided by other health care providers other than agency staff during this episode of care?

Optimal Strategy/Technique

- Document medication education consistently and in real time, capturing data on flow sheets as well for paper systems by all providers.
- Review flow sheets or software applications completed during episode of care to respond to this item. If none available, read the clinical notes.

Tips

- 1. Determine when the previous OASIS assessment occurred to establish the quality episode for reporting at this transfer or discharge not to inpatient facility assessment time point.
- 2. Medication instruction should include monitoring the effectiveness of drug therapy, drug reactions, and side effects, and how and when to report problems that may occur.
- 3. Begin documenting evidence of these instructions for each medication on a flow sheet or in a software application for easy retrieval at this transfer or discharge time-point.

M2015 Process Implications

Clinical Recommendations

- Reinforce the roles of nurses and therapists in medication education.
- Conduct in-service programs for all clinicians, as needed, on medication therapy and patient education techniques.
- Develop/adopt medication education materials for use for patient teaching.
- Create flow sheets for capturing medication education teaching in real time.
- Create/adopt clinical teaching sheets.

Operational Recommendations

- Establish agency policies and performance standards requiring comprehensive education of patients/caregivers in medications to ensure best practice.
- Establish documentation procedures to ensure the capture of details reflective of best practice for medication education or ensure that this information is captured in electronic record or on flow sheets in paper records.
- Conduct audits of clinical documentation on a routine basis to evaluate software performance or ensure compliance with documentation polices.

M2020	Management of Oral Medications: <u>Patient's current ability</u> to prepare and take <u>all</u> oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. <u>Excludes</u> injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)
	 0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
	1 - Able to take medication(s) at the correct times if:(a) individual dosages are prepared in advance by another person; <u>OR</u>
	 (b) another person develops a drug diary or chart. 2 - Able to take medication(s) at the correct times if given reminders by another person at the appropriate times
	 3 - <u>Unable</u> to take medication unless administered by another person. NA - No oral medications prescribed.
Item Inte	ent
The intent "complian medicatio The patie	is intended to identify the patient's ability to take all oral (p.o.) medications reliably and safely at all times. It of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and ce" are not the focus of these items. These items address the patient's ability to safely take oral ns, given the current physical and mental/emotional/cognitive status, activities permitted, and environment not must be viewed from a wholistic perspective in assessing ability to perform medication management. In the temporarily or permanently limited by:
- e - s	hysical impairments (e.g., limited manual dexterity) motional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear) ensory impairments, (e.g., impaired vision, pain) nvironmental barriers (e.g., access to kitchen or medication storage area, stairs, narrow doorways)
Time Po	ints Item(s) OC DC
Optimal Q	uestion
•	n you tell me which medications you take?
	nat times do you take them each day?
• Wi	nere do you keep your medications and how do you get them when it is time to take them?
• Do	bes anyone help you with your oral medications by reminding you to take them, creating a list,

filling a pill box, opening the bottles?

Optimal Strategy/Technique

- Observe the patient get meds from where they are stored; demonstrate how they get them out of the container and what they do to remember to take them.
- Have patient read medication labels to determine proper dosing.
- For each medication, ask the patient how it is taken, how often, and what techniques are used to remember multiple dosing in the day.
- Verify patient responses with caregiver.
- For patient who lives in ALF or personal care homes focus on ability, not policy of facility on medication storage/distribution.
- If using a planner device, determine whether the patient or caregiver is filling the device, creating the reminder list.

Tips

1. Consider the patient's ability to safely complete all tasks associated with taking oral medications; getting it from where it is stored, reading and interpreting label instructions, preparing it (opening bottles, pouring, breaking tablets, etc.), and reliably taking correct dose at proper time.

2. Excludes:

- Knowledge about medications; effects and side effects, etc.
- Filling, reordering and obtaining.
- 3. This item number reports the patient's ability to take the majority of his/her medication doses. If the patient's ability varies among the medications, report what is true for the medication requiring the most assistance.
- Assistance refers to in person human intervention of any kind; verbal cuing and/or hands on assistance.
- Response 1 refers to patients who require assistance in setting up one or any of their medications.
- 6. Response 2 refers to patients who require in person reminders to take one or any of their medications.

M2030 Management of Injectable Medications: Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. Excludes IV medications. O - Able to independently take the correct medication(s) and proper dosage(s) at the correct times. 1 - Able to take injectable medication(s) at the correct times if: (a) individual syringes are prepared in advance by another person; OR (b) another person develops a drug diary or chart. 2 - Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection 3 - Unable to take injectable medication unless administered by another person. NA - No injectable medications prescribed.

Item Intent

This item is intended to assess the patient's ability to take **all** injectable medications reliably and safely at **all** times. The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely manage injectable medications, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a wholistic perspective in assessing ability to perform medication management. Ability can be temporarily or permanently limited by:

- physical impairments (e.g., limited manual dexterity)
- emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)
- sensory impairments, (e.g., impaired vision, pain)
- environmental barriers (e.g., access to kitchen or medication storage area, stairs, narrow doorways)

Time Points Item(s)

SOC ROC FU DC

Optimal Question

Can you show me/tell me exactly what you do when you take your injection?

Optimal Strategy/Technique

- Observe the patient get injectable medications and supplies from where they are stored, demonstrate how they draw up the medication, select the proper site, inject the medication, dispose of supplies and what he/she does to remember to take them.
- Verify patient reports with caregiver.

- 1. Report patient's ability for any injectable medication expected to be administered in the home during the episode of care even if it is not administered on the day of the assessment.
- 2. Include assessment of ability to not only draw up and administer injection but to also dispose of syringe properly.
- 3. Conduct assessment prior to initiation of teaching to establish baseline performance.
- 4. Do not include assessment of ability to fill syringe if medication provided in prefilled syringe.
- 5. For patients on multiple injectable medications, score based on that medication with which most assistance is needed.
- Response 1 refers to patients who require assistance in setting up/drawing up one or any of their medications.
- Response 2 refers to patients who require in person reminders to take one or any of their medications.
- 7. Orders for a nurse to administer the injection infers that the patient is unsafe/unable to self-inject: select response 3 Unable.
- 8. If injection not due on day of assessment, assess and report on ability by asking patient to describe and demonstrate the steps for administration.
- 9. Exclude injections received outside of the home.

M2040

Prior Medication Management: Indicate the patient's usual ability with managing oral and injectable medications prior to this current illness, exacerbation, or injury. Check only **one** box in each row.



Functional Area	Independent	Needed Some Help	Dependent	Not Applicable
a. Oral medications	□0	□1	□ 2	□ na
b. Injectable medications	□0	□1	□ 2	□ na

Item Intent

Identifies changes that have occurred in the patient's ability to manage all prescribed oral and injectable medications since the onset of the current illness, exacerbation of a chronic condition, or injury (whichever is most recent) that initiated this episode of care. The intent of the item is to identify the patient's prior ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. This item is used for risk adjustment and can be helpful for setting realistic goals for the patient.

Time Points Item(s)

SOC ROC

Optimal Question(s)

 Prior to this illness or injury that resulted in us caring for you, did you take any medications by mouth or injection? How much help did you need to take them safely?

Optimal Strategy/Technique

- Have patient or caregiver describe how medications were taken prior to this illness, exacerbation or injury that resulted in this episode of care.
- Observe dates on medication labels.
- Review H and P for list of previous medications and identification of physical or mental deficit that would affect safe independent medication administration.
- Verify patient reported information with caregiver.

Zips

- 1. Time frame under consideration is the time **prior** to the current illness, exacerbation, or injury that initiated this SOC/ROC episode of care.
- 2. When ability varied among the medications, select the response for the medication requiring the greatest assistance.
- 3. Assistance refers to in person human intervention of any kind, verbal or hands on, etc.

M2100 Types and Sources of Assistance: Determine the level of caregiver ability and willingness to provide assistance for the following activities, if assistance is needed. (Check only **one** box in each row.)

M2100

Ту	/pe of Assistance	No assistance needed in this area	Caregiver(s) currently provides assistance	Caregiver(s) need training/ supportive services to provide assistance	Caregiver(s) not likely to provide assistance	Unclear if Caregiver(s) will provide assistance	Assistance needed, but no Caregiver(s) available
a.	ADL assistance (e.g., transfer/ ambulation, bathing, dressing, toileting, eating/feeding)	□0	□ 1	□ 2	□3	□ 4	□ 5
b.	IADL assistance (e.g., meals, housekeeping, laundry, telephone, shopping, finances)	0	□ 1	□2	□3	□ 4	□ 5
C.	Medication administration (e.g., oral, inhaled or injectable)	_ o	□ 1	<u> </u>	□ 3	□ 4	□ 5
d.	Medical procedures/ treatments (e.g., changing wound dressing)	□0	□ 1	□ 2	□3	□ 4	□ 5
e.	Management of Equipment (includes oxygen, IV/infusion equipment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies)	□ 0	☐ 1	□ 2	□ 3	□ 4	□ 5
f.	Supervision and safety (e.g., due to cognitive impairment)	□0	□ 1	□ 2	□ 3	□ 4	□ 5
g.	Advocacy or facilitation of patient's participation in appropriate medical care (includes transportation to or from appointments)	□0	<u> </u>	□2	□3	□ 4	□5

Item Intent

Identifies availability and ability of the caregiver(s) (other than home health agency staff) to provide categories of assistance needed by the patient.

Time Points Item(s)

SOC ROC DC

Optimal Question(s)

- Who helps you with care issues, household activities, etc? List the types/categories of assistance in words they can understand, offering examples reflective of his/her situation/needs.
- Who could you call on to help you for any reason? Are there activities with which the patient needs assistance?

Optimal Strategy/Technique

- Observe the environment and relationship between caregiver(s) and patient.
- Interview the patient and caregiver(s) and observe assistance with select tasks when possible to determine willingness and ability to assist.
- Use the five day window for SOC to gather additional information when needed.

- 1. Remember that "e.g." means <u>for example</u>. Therefore, the list provides examples of activities, but is not limited to those examples. Other like kind activities, depending on the patient's condition and situation should be considered before responding. Consider any "skilled treatment/procedure" or non skilled activity necessary to maintain the patient safely in his/her environment. The clinician should consider all disciplines involved in the plan of care to determine the appropriate response for the team.
- If the need for assistance varies by item within a category, select the response reflecting the task requiring the greatest level of assistance and the availability and ability of the caregiver to meet that need.
- 3. If the availability and ability of a caregiver varies within a row, select the response that reflects the greatest need of the caregiver.
- 4. Assistance means in person human intervention of any kind (e.g., verbal cuing, hands on help, etc.).
- 5. If there is no need for the activities in the category, or the patient is independent in performing needed activities, select "No assistance needed in this area".
- 6. Use the M2100 matrix to identify unmet needs and assure appropriate Plan of Care is in place for the episode when completed at SOC/ROC and after discharge when completed at the discharge time point.
- 7. Consider referrals to MSW, HHA, and rehab based on this assessment.
- 8. Include documentation in other parts of the clinical record to identify the activities with which the patient needs assistance, the availability and ability of the caregiver to support your choices.

M2110 How Often does the patient receive ADL or IADL assistance from any caregiver(s) (other than home health agency staff)? 1 - At least daily 2 - Three or more times per week 3 - One to two times per week 4 - Received, but less often than weekly 5 - No assistance received UK - Unknown* *at discharge, omit Unknown response.

Item Intent

Identifies the frequency of the assistance with ADLs (e.g., bathing, dressing, toileting, transferring, ambulating, feeding, etc.) or IADLs (e.g., medication management, meal preparation, housekeeping, laundry, shopping, financial management) provided by any non-agency caregivers.

Time Points Item(s)

SOC ROC DC

Optimal Question

 How often does someone help you with personal care and/or household tasks? List tasks specifically in words the patient can understand if necessary.

Optimal Strategy/Technique

- Ask open ended questions, e.g., "how often or when" to determine current frequency of assistance for any ADL/IADL task.
- Verify patient reported information with caregiver.

- 1. This item refers to any ADL/IADL item, both those listed and not listed in the OASIS-C document by any non agency provider.
- 2. Do not select "unknown" if possible; used in risk adjustment of patient outcomes.
- 3. Consider use of the 5 day window at SOC and 2 days at ROC to obtain complete and accurate information. Communicate information to the person completing discharge assessment.

Therapy Need: In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? (Enter zero ["000"] if no therapy visits indicated.) (_____) Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined). DA - Not Applicable: No case mix group defined by this assessment.

Identifies the total number of therapy visits (physical, occupational, or speech therapy combined) planned for the Medicare payment episode for which this assessment will determine the case mix group, and only applies to payers utilizing a payment model based on case mix group assignment.

Time Points Item(s)

SOC ROC FU

Optimal Question

What is the total number of therapy visits ordered for this patient (include all rehab services)?

Optimal Strategy/Technique

- Determine therapy need <u>after</u> completion of assessment and formulation of home health plan of care.
- Interdisciplinary communication/coordination optimizes accuracy in visit count projections.
- Use the 5 days following SOC and 2 days after ROC and Follow-up if needed for communication.

- 1. Complete this item on or within 5 days of SOC, 2 days for ROC and Follow-up (Recert) after collaboration with rehab services and for greatest accuracy.
- 2. Secure physician's orders for visits upon completion of rehab evaluation.
- 3. If collaboration is not possible, an estimation of the projected therapy visits based on the medically necessary and reasonable need identified and supported by the comprehensive assessment is acceptable.
- 4. Consider physician protocols for therapy visit projection.
- 5. Select N/A at ROC UNLESS a ROC occurs after an intervening hospital stay and there is a return home during the last 5 days of an episode. In those cases where the ROC serves as the recertification assessment, select response based on therapy need for the subsequent certification period. See OASIS Considerations for Medicare PPS Patients, revised October 2007 for more information. http://www.cms.hhs.gov/OASIS/Downloads/OASISConsiderationsforPPS.pdf
- 9. At recertification record the number of therapy visits ordered/projected for the subsequent episode.
- 10. The final claim will be paid based on the actual number of therapy visits made to the patient. When the actual number does not match the projected number at SOC/ ROC or Follow-up, the computers at the RHHI will automatically adjust the predicted number up or down and there is no action required by the agency to correct M2200 on the original document.
- 11. Therapy visits affect risk adjustment and reimbursement.
- 12. Complete item with 3 digits.

M2250 Plan of Care Synopsis: (Check only <u>one</u> box in each row.) Does the physician-ordered plan of care include the following:

M2250

Plan / Intervention	No	Yes	Not Appli	icable
Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings	□0	<u> </u>	□ na	Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference
Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	0	<u> </u>	□ na	Patient is not diabetic or is bilateral amputee
c. Falls prevention interventions	□ o	<u> </u>	□na	Patient is not assessed to be at risk for falls
d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	□ o	□ 1	□ na	Patient has no diagnosis or symptoms of depression
e. Intervention(s) to monitor and mitigate pain	0	<u> </u>	☐ na	No pain identified
f. Intervention(s) to prevent pressure ulcers	0	□ 1	☐ na	Patient is not assessed to be at risk for pressure ulcers
g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician	_ o	<u> </u>	□ na	Patient has no pressure ulcers with need for moist wound healing

Item Intent

Identifies if the physician-ordered home health plan of care incorporates specific best practices. The "physician ordered plan of care" means that the patient condition has been discussed and there is agreement as to the plan of care between the home health agency staff and the physician.

This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.

Time Points Item(s)

SOC ROC

Optimal Question

- Question a.
 - Has the physician been asked to establish parameters for reporting changes?
- Questions b. through g.
 If the patient has any of the listed conditions, were verbal or written orders obtained for intervention(s) before the end of the 5 day (SOC) or 2 day windows (ROC)?

Optimal Strategy/Technique

- Seek physician approval to use agency standardized parameters, as appropriate, if physician chooses not to identify patient-specific parameters.
- Establish agency practice for intake staff and coordinators to routinely obtain patient-specific parameters.

- Establish agency practice of recommending to physicians best practices in all plans of care for patients with chronic and high risk conditions (including parameters). Consider use of a 'worksheet' or other standard system when taking referrals.
- Include documentation of verbal orders as well as written orders when determining the correct response.
- Ensure ready access to referral information and verbal order documentation.

Tips

- 1. This question relates to presence of orders, not whether an assessment occurred for each item.
- 2. The responses reflect the entire plan of care and not only the discipline of the clinician responding to the question.
- 3. Physician ordered Plan of Care means that the patient condition was discussed and there was agreement as to the plan of care between the home health agency staff and the patient's physician.
- 4. Determine if the relevant condition(s) exists through the assessment process (i.e. diabetes, falls risk, depression, pain, potential for pressure ulcers, pressure ulcers). If the condition exists, consult the physician for orders to include the associated best practice interventions in the Plan of Care.
- 5. Document communication with physician and results of the contact in a designated area of the record for efficient retrieval at transfer and discharge not to inpatient facility time points.
- 6. Consider reading the possible responses from right to left to ensure that the most appropriate response is selected. "No" is never a best practice for the relevant items.
- 7. "And" means POC must contain BOTH elements, (e.g. orders to monitor AND mitigate pain).
- 8. Select Yes when:
 - Physician agrees to the relevant best practices or
 - Physician approves use of agency parameters, as appropriate, for patient-specific parameters,
 - AND orders are received in allotted time frame, within 5 days after the SOC, and 2 days of facility discharge or knowledge of it at ROC
- 9. Select "No" when the relevant best practices are not included in the Plan of Care. Document communication with physician and reason when known:
 - Orders not received in allotted time frame, within 5 days after the SOC, and 2 days of facility discharge or knowledge of it.
 - Physician not contacted or would not agree to best practice.
- 10. Collaborate with and educate referral sources in best practices and acute care hospitalization prevention.
- 11. This process measure requires physician orders; therefore the individual providing the orders must meet the CMS definition for a physician (MD, Doctor of Osteopathic Medicine, Doctor of Podiatric Medicine) and not be a physician designee acting on behalf of the physician.
- 12. Consider use of other services as an interventional strategy.

M2250 Process Implications

Clinical Recommendations

- Develop agency tool for two-way communication with physician/referral source.
- Establish and adopt standardized agency clinical tools e.g., parameters; clinical pathways to insure interventions are included in plans of care.
- Base responses to confirmed presence of each condition on assessments and/or use of standardized tools (falls, pain, PU prevention, and management, etc).
- Ensure that all needed clinical interventions are included in the Plan of Care and documented.

Operational Recommendations

- Develop agency process for tracking physician agreement/modification to best practices.
- Integrate best practices into the referral process via intake and liaisons.
- Develop templates for potential interventions/best practices.
- Educate staff on best practices.
- Establish standardized locations for documentation in medical record/electronic documentation system.

M2300	Emergent Care: Since the last time OASIS data were collected, has the patient utilized a hospital emergency department (includes holding/observation)?
	 □ 0 - No [Go to M2400] □ 1 - Yes, used hospital emergency department WITHOUT hospital admission □ 2 - Yes, used hospital emergency department WITH hospital admission □ UK - Unknown [Go to M2400]
assessr	tent es whether the patient was seen in a hospital emergency department since the previous OASIS ment. Responses to this item include the entire period since the last time OASIS data were d, including current events.
	oints Item(s)
Optimal (Question
• \	When was the last time you went to the emergency room?
Optimal \$	Strategy/Technique
• (Jse internal resources to validate info, call hospital, etc.
• (Jtilize family members.
• l	Look for hospital/ER paperwork in home (e.g. DC instructions).
Tips	
1. D	etermine the last time OASIS was completed in order to establish the quality episode for

- reporting.
- 2. This item is now limited to EMERGENCY ROOM care
- 3. Select NO when patient was a direct admit to a hospital bed and did not enter the hospital through the emergency room.
- 4. Educate the patient and caregiver to inform the agency when they have had an emergency room
- 5. Ask about emergency room use at every visit.

M231	Reason for Emergent Care: For what reason(s) did the patient receive emergent care (with or without hospitalization)? (Mark all that apply.)
	☐ 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
	2 - Injury caused by fall
	3 - Respiratory infection (e.g., pneumonia, bronchitis)
	4 - Other respiratory problem
	5 - Heart failure (e.g., fluid overload)
	6 - Cardiac dysrhythmia (irregular heartbeat)7 - Myocardial infarction or chest pain
	8 - Other heart disease
	9 - Stroke (CVA) or TIA
	10 - Hypo/Hyperglycemia, diabetes out of control
	11 - GI bleeding, obstruction, constipation, impaction
	12 - Dehydration, malnutrition
	☐ 13 - Urinary tract infection
	14 - IV catheter-related infection or complication
	15 - Wound infection or deterioration
	16 - Uncontrolled pain
	17 - Acute mental/behavioral health problem
	 18 - Deep vein thrombosis, pulmonary embolus 19 - Other than above reasons
	UK - Reason unknown
• •	_
	Intent
Identi	ifies the reasons for which the patient received care in a hospital emergency department.
Time	Points Item(s)
TRF	DC
Optima	al Question
•	What did they do for you in the emergency room? What was wrong?
•	What medical conditions and/or incidents caused this patient to be treated in the emergency
	room?
Optima	al Strategy/Technique
•	Select any/all reason(s) for which the patient received emergency room treatment since the last OASIS data collection.
•	Verify patient reported information with caregiver.
Tips	
1.	Determine the last time OASIS was completed in order to establish the quality episode for
	reporting.
2.	Review record to ensure identification of ALL emergency room visits since last OASIS.
3.	Options have been expanded and should be reviewed before selecting reasons.
4.	Response 2 includes injuries from falls in or outside of the home.
5.	Select Response 19 for other accidents or injuries.
_	
6.	Select response 15 for wound deterioration of existing wounds and not the development of new wounds.
7.	Select Response 19 for new wound (not a result of a fall).
8.	Consider completion of OASIS assessment RFA #5 (other follow-up) when patient uses emergent

planning.

9. Make an effort to avoid use of "unknown" as this item affects risk adjustment and future care

M2400

Intervention Synopsis: (Check only <u>one</u> box in each row.) Since the previous OASIS assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?



	Plan / Intervention	No	Yes	Not Applicable		
a.	Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	□ o	□ 1	☐ na	Patient is not diabetic or is bilateral amputee	
b.	Falls prevention interventions	0	1	□ na	Formal multi-factor Fall Risk Assessment indicates the patient was not at risk for falls since the last OASIS assessment	
C.	Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	□ o	<u> </u>	□na	Formal assessment indicates patient did not meet criteria for depression AND patient did not have diagnosis of depression since the last OASIS assessment	
d.	Intervention(s) to monitor and mitigate pain	□ 0	<u> </u>	☐ na	Formal assessment did not indicate pain since the last OASIS assessment	
e.	Intervention(s) to prevent pressure ulcers	□ o	<u> </u>	☐ na	Formal assessment indicates the patient was not at risk of pressure ulcers since the last OASIS assessment	
f.	Pressure ulcer treatment based on principles of moist wound healing	□ 0	<u> </u>	□ na	Dressings that support the principles of moist wound healing not indicated for this patient's pressure ulcers OR patient has no pressure ulcers with need for moist wound healing	

Item Intent

Identifies if specific interventions focused on specific problems were both included on the physicianordered home health plan of care AND implemented as part of care provided during the home health care episode (at the time of the previous OASIS assessment or since that time). The physician-ordered plan of care means that the patient condition was discussed and there was agreement as to the plan of care between the home health agency staff and the patient's physician.

This item is used to calculate process measures to capture the use of best practices. The problemspecific interventions referenced in the item may or may not directly correlate to stated requirements in the Conditions of Participation.

The formal assessment that is referred to in the last column for rows b – e refers to the assessment defined in OASIS items for M1240, M1300, M1730, and M1910.

Time Points Item(s)

TRF DC

Optimal Question

• If the patient has needs related to the listed conditions, are there physician orders for the relevant interventions AND were they carried out since the previous OASIS assessment?

Optimal Strategy/Technique

- Review POC & documentation in a systematic standardized way.
- Refer to software programs or paper tools that were initiated at SOC to capture documentation of interventions in <u>real</u> time or read clinical record.
- Select response reflecting actions of any team member during the quality episode.

Tips

1. "Since the previous assessment" means "<u>at</u> the time of the last OASIS assessment (SOC, ROC, Recertification, or Other Follow-up), **or** since that time."

- 2. Determine when the most previous OASIS assessment occurred to establish the quality episode for reporting this information.
 - Responses selected by the discharging or transferring clinician should represent the <u>team's</u>
 plan of care and interventions by any provider during the period for report and not just actions
 of the assessing clinician.
- 3. Consider reading the responses from right to left to ensure the most appropriate response.
- 4. Physician ordered Plan of Care means that the patient condition was discussed and there was agreement as to the plan of care between the home health agency staff and the patient's physician.
- 5. An order received and a referral made for "other" treatment of depression is considered a "Yes" response, even if the treatment is never actually provided. This does not apply to interventions for diabetes, pain, falls risk, etc.
- 6. "Yes" is the answer for ordered interventions later determined to be unnecessary.
- 7. "No" is the answer for ordered interventions that the patient declines to receive.
- 8. "No" is never best practice for the relevant items.
- 9. NOTE: lettering (a-g) in M2250 POC Synopsis Grid differs from (a-f) in M2400 Intervention Synopsis Grid in that M2400 excludes reference to patient specific parameters for physician notification.
- 10. A "No" response at M2250 would not require a "No" response at 2400 if interim orders were received.

M2400 Process Implications

Clinical Recommendations

- Create an agency culture focusing on case coordination and treatment of the "total" patient with a focus on what "we" did for the patient as opposed to what "I" did alone.
- Renew focus for clinical practice to include: assessment, <u>obtaining orders</u>, <u>implementing interventions</u>, and documentation.
- Identify best practices for each condition.
- Promote added interventions as needed for individual patient.
- Patients who initially refuse interventions may be less reluctant as the episode proceeds. Encourage clinician to try again.
- · Educate clinicians on best practices.

Operational Recommendations

- Increase education for staff regarding appropriate interdisciplinary referrals, enhanced collaboration, and mutual accountability for documentation.
- Develop and implement a process for tracking both the physician order(s) and related interventions by date (for each discipline).
- Develop information hand-off processes between and among disciplines to include information from all members of the interdisciplinary team.
- Evaluate internal processes for OASIS completion and communication at Transfer and Discharge, esp. when one clinician is responsible for Transfer or D/C OASIS on a (complex) multidisciplinary case.

M2410	To which Inpatient Facility has the patient been admitted? 1 - Hospital [Go to M2430] 2 - Rehabilitation facility [Go to M0903] 3 - Nursing home [Go to M2440] 4 - Hospice [Go to M0903] NA - No inpatient facility admission	M2410
Item Inte	the type of inpatient facility to which the patient was admitted.	
Time Po	ints Item(s)	

Optimal Question

• Did this patient go from home to hospital, nursing home or rehab facility as an inpatient, where he/she stayed for more than 24 hours?

Optimal Strategy/Technique

- Interview patient/caregiver.
- Contact the hospital utilization department if questions exist about the type of facility or bed within a facility to which the patient was admitted.

- 1. Died in Ambulance select "NA".
- 2. "Holds" in emergency rooms and/or observation beds do NOT qualify as inpatient admissions, regardless of how long the patient remains (eg. hours or days).
- 3. The list of inpatient facility types differ in this item from those found in M1000.
- 4. Determine whether the hospital has swing beds, separately licensed skilled nursing facility beds, and/or separately licensed rehabilitation beds within its walls. If so, determine what type of bed the patient was confined to.
- 5. Response 1 "Hospital" includes
 - Acute care hospital
 - Long term care hospital

M242	Discharge Disposition: Where is the patient after discharge from your agency? (Choose only one answer.)
	☐ 1 - Patient remained in the community (without formal assistive services)
	2 - Patient remained in the community (with formal assistive services)
	3 - Patient transferred to a non-institutional hospice
	4 - Unknown because patient moved to a geographic location not served by this agency
	UK - Other unknown
	[Go to M0903]
	Intent
Ident	tifies where the patient resides after discharge from the home health agency.
Time	e Points Item(s)
DC	
Optim	al Question
•	Where will you be living after we discharge you? What kind of help will you be getting from your family, friends, or the community?
Optim	al Strategy/Technique
•	Discuss discharge plans with other agency providers and confirm status with patient/caregiver.
Tips	
1.	Response 2 "remained in the community" would be selected when the patient is discharged from the agency and readmitted to the agency due to a change in payer source.
2.	Note that Option 3 "transferred" in this situation constitutes discharge to hospice services at home and is not treated as a transfer to inpatient facility.

3. Receipt of assistance from family and friends does not qualify as "formal assistance," unless services are reimbursed through a consumer directed care program or Medicaid Waiver Program.

M243	Reason for Hospitalization: For what reason(s) did the patient require hospitalization? (Mark all that apply.)
	☐ 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
	2 - Injury caused by fall
	3 - Respiratory infection (e.g., pneumonia, bronchitis)
	4 - Other respiratory problem
	5 - Heart failure (e.g., fluid overload)6 - Cardiac dysrhythmia (irregular heartbeat)
	☐ 7 - Myocardial infarction or chest pain
	8 - Other heart disease
	9 - Stroke (CVA) or TIA
	10 - Hypo/Hyperglycemia, diabetes out of control
	□ 11 - GI bleeding, obstruction, constipation, impaction
	12 - Dehydration, malnutrition
	13 - Urinary tract infection
	14 - IV catheter-related infection or complication
	15 - Wound infection or deterioration16 - Uncontrolled pain
	☐ 17 - Acute mental/behavioral health problem
	☐ 18 - Deep vein thrombosis, pulmonary embolus
	19 - Scheduled treatment or procedure
	20 - Other than above reasons
	☐ UK - Reason unknown
	[Go to M0903]
Item	Intent
Identi	fies the specific condition(s) necessitating hospitalization.
Time	Points Item(s)
TRF	
Optima	al Question
•	What medical conditions and/or incidents were the basis for this patient being admitted to the hospital?
Optima	al Strategy/Technique
•	Validate reason for hospitalization with reliable sources.
•	Verify patient reported information with caregiver.
Tips	
1.	Record any/all reasons patient requires hospitalization
2.	Note that options have been expanded from OASIS B1 and should be reviewed before selecting reason for hospitalization.
3.	Response 2: Note change.
-	Includes any falls, not just falls at home.
	Excludes other accidents.

4. Select response 20 for other accidents or injuries.

M244	For what Reason(s) was the patient Admitted to a Nursing Home? (Mark all that apply.)
	☐ 1 - Therapy services
	2 - Respite care
	3 - Hospice care
	4 - Permanent placement
	5 - Unsafe for care at home
	☐ 6 - Other ☐ UK - Unknown
	[Go to M0903]
	Intent ifies the reason(s) the patient was admitted to a nursing home.
	Points Item(s)
TRF	
Optim	al Question
•	What care needs resulted in this patient being admitted to a nursing home?
Optim	al Strategy/Technique
•	Contact family/caregiver, physician, or nursing home to determine reason for transfer.
•	Verify patient reported information with caregiver.
Tips	
1.	Multiple reasons for admission may exist and should be captured.
2.	The agency clinical record should include documentation that reflects the patient's condition necessitating nursing home admission if placement was planned.

M0903 Date of Last (Most Recent) Home Visit:

___/__/__/________ month / day / year M0903

Item Intent

Identifies the last or most recent home visit by any agency provider that is included on the Plan of Care.

Time Points Item(s)

TRF DC DAH

Optimal Question

What was the date of the last physician ordered visit made to this patient by any agency provider?

Optimal Strategy/Technique

Collaborate with appropriate office staff to determine when the last visit (billable or non-billable)
was made by any agency provider (SN, PT, SLP, OT, home health aide, MSW) under the plan of
care.

- 1. Last visit does not necessarily need to be a billable visit/service but must be an ordered visit.
- 2. If agency policy requires an RN to do the discharge assessment, include an order for this non billable visit on the plan of care. This visit is the last visit date.
- 3. The date of the last home visit (M0903) will likely be the same as M0090, date of the assessment completed except:
 - With a transfer to an inpatient facility
 - Patient death at home
- 4. In the case of an "unexpected discharge" the date of the last home visit M0903 must always be prior to the M0090 date.

M0906

Discharge/Transfer/Death Date: Enter the date of the discharge, transfer, or death (at home) of the patient.

M0906

Item Intent

Identifies the actual date of discharge, transfer, or death (at home), depending on the reason for assessment.

Time Points Item(s)

TRF DC DAH

Optimal Question

None

Optimal Strategy/Technique

None

- 1. Record actual date of the occurrence for:
 - Transfer to inpatient facility
 - · Death occurring at home
- 2. If the agency policy requires the discharge date to be the date of a physician's order for discharge, the discharge assessment must be completed on the date of the physician order to discharge or within 48 hour after that date. Otherwise, the date of discharge is based on agency policy (e.g. last visit date, date paperwork completed, etc.).
- 3. The discharge date must be on or after the last visit date.
- 4. Regulation requires that the assessment be completed (M0090) on or no more than 48 hours after the discharge/transfer/death date.